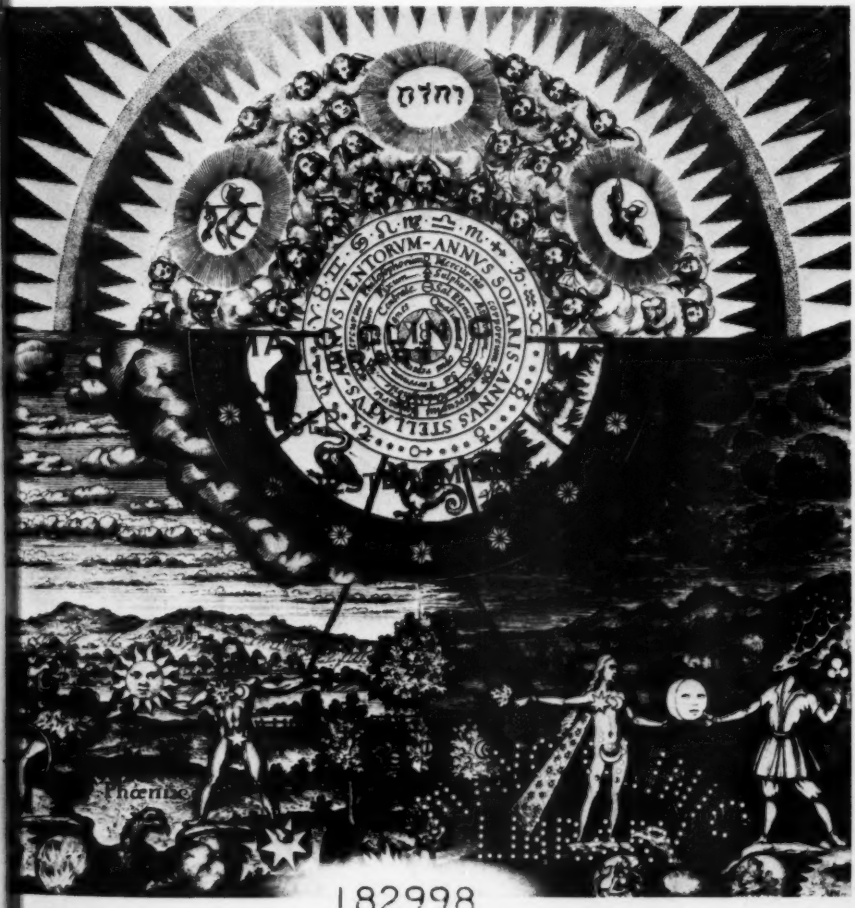
mental health digest

National Clearinghouse for Mental Health Information, Vol. 4, No. 7, July 1972

#12, DECEMBER

mhd



182998

cover story

Sexual and Reproductive Behavior

The pictures on the cover are details from an early seventeenth century pictorial representation of the place of alchemy in the universe. Man carries the symbol of Sol, or sophic sulphur, the masculine principle; woman carries the symbol of Luna, or sophic mercury, the feminine principle. Woman stands in the Hermetic stream and holds a bunch of grapes to signify fertility. Both principles take part in the alchemical operation and are linked to the macrocosm by chains.

Picture courtesy the National Library of Medicine

The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature. The condensations are published with the approval of the authors and publishers for use in the *Mental Health Digest* only. Readers interested in particular digests are urged to consult the journal or other source in which the material first appeared or to ask the authors for reprints.

Material contained in the *Digest* does not necessarily reflect the opinions, official policy, or position of the National Institute of Mental Health.

Editorial Advisory Board

Bertram S. Brown, M.D., Chairman

William E. Bunney, M.D.
Harry P. Cain II, Ph.D.
Morris E. Chafetz, M.D.
Robert A. Cohen, M.D., Ph.D.
John C. Eberhart, Ph.D.
James A. Goodman, M.D.
James D. Isbister
Thomas F. A. Plaut, Ph.D.
Gian C. Salmoiraghi, M.D., Ph.D.
Claudewell S. Thomas, M.D.
Louis A. Wienckowski, Ph.D.

Editor: Lorraine Bouthilet, Ph.D.

to subscribe

The *Mental Health Digest* is available on subscription from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. Subscription price: $3.50 a year; Single copy: 30¢. For foreign mailing, add $1.00. (No additional postage is required for Canada, Mexico, and Central and South American countries except Argentina, Brazil, British Honduras, French Guiana, Guyana, and Surinam.) Please make check or money order payable to the Superintendent of Documents. An annual subscription runs for 12 consecutive issues and begins when orders are processed. However, a subscription may be backdated to include issues already published in the current volume when the issues are available. Issues for back years, when available, are sold at the single copy price. The expiration date is printed on the top line of the address label. Change of address and complaints about nonreceipt of issues should be sent to the Superintendent of Documents, and should include the old address, preferably a mailing label, as well as the new address.

Use of funds for printing this publication approved by the Director of the Bureau of the Budget, May 20, 1968.

contents

mental health digest, Vol. 4, No. 7, July 1972

sexual and reproductive behavior

1 Procedures for Exploring Women's Childbearing Motivations, Alleviating Childbearing Conflicts and Enhancing Maternal Role Development
by Mark Flapan
from the *American Journal of Orthopsychiatry*

6 Teaching Human Sexuality: The Use of Discussion Groups and Teaching Aides in a College Course
by Eleanor S. Morrison
from *The Family Coordinator*

9 Toward a New Feminine Psychology
by Natalie Shainess
from the *Notre Dame Journal of Education*

13 The Sexually Oppressed
by Harvey L. Gochros
from *Social Work*

19 The New Impotence
by George L. Ginsberg
from the *Archives of General Psychiatry*

21 Behavioural Factors in Non-Coital Methods of Contraception: A Review
by Barry L. Borland
from *Social Science and Medicine*

29 Prenatal Stress Feminizes and Demasculinizes the Behavior of Males
by Ingeborg L. Ward
from *Science*

contents continued

31 Effect of Brain Stimulation in Positive and Negative Reinforcing Regions in the Rat on Content of Catecholamines in Hypothalamus and Brain
by M. E. Olds and A. Yuwiler
from *Brain Research*

35 The Utilization of Research
by Asher Soloff
from *Rehabilitation Literature*

40 The Viet Nam Veteran: Psychosocial Casualties
by Peter G. Bourne
from *Psychiatry in Medicine*

mental health and the law

43 The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a new Mental Health Law
by Marc F. Abramson
from *Hospital and Community Psychiatry*

46 mental health news digests

Procedures for Exploring Women's Childbearing Motivations, Alleviating Childbearing Conflicts and Enhancing Maternal Role Development

Mark Flapan and Helene Schoenfeld

The early period of family formation is an opportune time for preventing family-life problems and promoting optimal family development. During this period, personal and marital conflicts related to childbearing and the manner of coping with changes generated by pregnancy and parenthood have long-range consequences for the mental health of parents and children.

In order to understand the nature of motivational conflicts related to childbearing and the personal and marital problems generated by pregnancy and parenthood, as well as to promote optimal family development, we developed an action research program for married couples in the early period of family formation. Couples were recruited to participate in the program prior to the birth of the first child, that is, during the time when they were either postponing childbearing, trying to conceive, or during early pregnancy. These couples have continued during their reproductive and parental careers from conception through pregnancy and the early years of parenthood; during periods of infertility and, in some cases, adoptive parenthood; or during a period of continued voluntary childlessness.

The procedures draw on psychoanalytic, psychodramatic, role-playing, self-confrontation, marriage counseling, and group discussion techniques. These are used in a variety of interpersonal settings: The interviewers meet with the husband alone and the wife alone, with the husband and wife together, with the couple and their parents, with husband, wife, and child, and with small groups of married couples.

This paper describes the procedures in the individual sessions with the wife alone, prior to and following the birth of her first child. The procedures explore the developmental and current life experiences that shape the woman's childbearing motivations and conflicts. They focus on her past and present relationship with her parents and siblings, relationship with her husband, identity as a woman, life aspirations as they relate to her orientations toward reproduction and parenthood, and early experiences of motherhood. The first six to eight sessions with the wife are scheduled every other week during the first several months in the program. Subsequent sessions are scheduled as the woman's reproductive and parental concerns and conflicts emerge or are exacerbated when she is postponing childbearing, in the process of deciding whether or not to begin childbearing, trying to conceive or experiencing reproductive difficulty, and during pregnancy, the postpartum period, and early years of parenthood. Women who are conflicted or apprehensive about childbearing or motherhood may arrange for additional sessions. This opportunity is also open for those who desire clarification of any area of concern generated by their participation in the program.

The first two procedures—Focused Recollections and Intra-Self Dialogs—are used with all women during their

initial sessions. In subsequent sessions, these and the other procedures are flexibily administered.

Focused Recollections

In order to enable a woman to understand her orientations toward childbearing and motherhood from the perspective of her developmental experiences, the interviewer engages her in "Focused Recollections." The participant leans back on a recliner while the interviewer sits beside and slightly behind her. She tries to recall all thoughts and feelings she has had about "having or not having children," "when you were a little girl," "as you were growing up," "before you were married," "since you've been married," and "more recently." No questions are asked until the woman indicates that she has completed her recollections. Then the interviewer asks questions to clarify the meanings she attributes to her experiences and to evoke additional reflections and memories. The physical position of the participant and the instruction to think aloud induce a reflective set or mood. This gives the woman an opportunity to produce salient associations with a minimum of influence from the interviewer.

The Focused Recollection procedure is flexible in that recollections may be specified for any constellation of life-experiences that is hypothesized to be significant in the development of orientations to childbearing and motherhood. Recollections of thoughts and feelings are elicited for pregnancy, labor and childbirth, breastfeeding, birth control, menstruation, sexual experiences, a woman's body, a man's body, being a woman, marriage and being a wife, being a mother, children, family life, housekeeping, work or a career, being sick, menopause, growing old, and death.

To aid the participant in gaining perspective on developmental experiences, the interviewer inquires about topics that may have been omitted or mentioned only in passing. For example, following Focused Recollections pertaining to "having or not having children" or "being a mother," a woman may be asked to recall her experiences in playing with dolls, taking care of younger siblings, or babysitting. Following a woman's review of menstruation, sex, contraception, and reproductive functioning, the interviewer asks for information that may not have been mentioned. For example, a woman may not include such specifics as regularity and length of cycle, extent of flow, signs of onset, menstrual dysfunction, awareness of mid-cycle, and variations in sexual response as related to the menstrual cycle. Elaboration of these details elicits attitudes and feelings that may be relevant to the woman's childbearing and maternal orientations.

After the birth of a baby, a variation of this procedure is used. The woman is asked to report subjective experiences and any thoughts, feelings, and fantasies "starting before the onset of labor, through delivery and the first view of the infant." In addition to its cathartic value, this enables her to discuss feelings of inadequacy, shame, or guilt, and provides the interviewer with the opportunity to offer reassurance and support.

Intra-Self Dialogs

The "Intra-Self Dialog" procedure was designed for an extensive and focused self-exploration of motivational conflicts related to childbearing and motherhood. To engage an individual in an Intra-Self Dialog, the interviewer asks the participant to

pretend that another "part of herself" is sitting in a chair opposite her. She is instructed to ask that "self" questions. Following are sample instructions for initiating Intra-Self-Dialogs relevant to several reproductive stages:

Postponing or Considering Childbearing: "Do you want a child because or in order to . . . ?" "Are you ready to have a child because . . . ?" "Are you reluctant or uncertain about having a child because . . . ?"

Pregnancy: "Are you afraid of (looking forward to) labor and delivery because . . ." "Since you've been pregnant, have you (your husband) been . . . ?" "Do you want to (not want to) breast-feed because . . . ?"

Early Motherhood: "Are you happy (unhappy) about being a mother because . . . ?" "Since you've been a mother have you (your husband) become . . . ?" "Do you want to wean your baby (continue nursing) because . . .?"

Any subject the interviewer considers significant can be explored in dialog form. If a woman poses a question such as, "I wonder if I'll have enough patience to take care of a child," this can be explored by instructing her to ask herself questions in the form of "Will you be impatient if your baby . . . ?"

After the participant has asked as many questions as occur to her, she is told to be that "part of herself" to whom the questions were addressed. Her audio-recorded questions are played back to her one at a time, and she responds to each question as fully as possible, verbalizing whatever thoughts and feelings the question evokes.

In order to explore particular family or other interpersonal situations, a woman may be engaged in one or more "Intra-Familial Dialogs." In this form of dialog, the participant pretends that her mother, father, husband, or other significant person is sitting opposite her. She asks that person questions beginning with a phrase such as, "When I have a child will you . . .?" or "Will you be the kind of father who . . . ?" When the questions are played back, the participant responds in the role of the family member she has addressed. She may add thoughts of her own that relate to the questions. In another version, the participant is instructed first to assume the role of her mother, father, spouse, etc., and from the other person's perspective to ask herself questions such as, "You should have a baby now because . . ." In answering the questions she includes what she might think and feel but possibly refrain from saying if the other person were actually present.

It is our impression that this procedure increases the ability and willingness of participants to delineate and explore their motivations and conflicts. The process involves the woman in active self-exploration. Questions voiced by the individual herself seem less threatening than similar questions asked by the interviewer. Furthermore, since an Intra-Self Dialog is based on a woman's knowledge of herself and her family situation, she raises questions that might not have occurred to the interviewer.

Imaginary Diary

Any experience that may have contributed to meanings associated with reproduction and childbearing may be further explored through an "Imaginary Diary." The woman is seated at a desk with pencil and paper and told to imagine that she keeps a diary. The interviewer ascertains the age at which an event occurred, such

as the first menstrual period, and asks the woman to pretend that this is the day the event took place. She begins by saying "Dear Diary," and describes aloud, as though she were writing, the thoughts, feelings, and reactions precipitated by this event.

Other experiences may be when she first became aware of the differences between boys and girls; the time she first learned about or discussed the "facts of life;" when she obtained her first brassiere; her first awareness of sexual sensations; her first and subsequent love experiences; the first time she had sexual intercourse; when she was making the decision to get married; her first gynecological examination; and when she was deciding to have a child or postpone childbearing.

We do not assume that the Imaginary Diary conveys a completely accurate account of life-experiences. However, when a woman "writes" a diary relating to some childhood event, her tendency to view childhood experiences from an adult perspective is lessened. The language and tone are frequently appropriate to the age-period designated, indicating that the woman is transposing herself in time and is to some degree able to recapture her past experience. The Imaginary Diary minimizes the individual's consciousness of the interviewer. This is indicated by the fact that women frequently express surprise that they were able to reveal such intimate experiences with a minimum of embarrassment.

"Imaginary Letters" is used to explore interpersonal concerns or motivations related to childbearing. For example, a woman may be asked to "write" (actually to talk aloud) an imaginary letter to her mother, indicating that she has decided to have a child as soon as possible, or that she has decided to postpone having her first child for a given period of time. In writing the letter, the woman reveals the thoughts and considerations that have entered into her decision. She then pretends to be her mother and answers the letter in the role of her mother. The exchange of imaginary letters can be repeated with father, sister, friend, or husband.

Maternal Role Practicum

Prior to the birth of a first child, many women have not participated in the physical care of an infant and have little knowledge of the impact that an infant may have on their daily living. Mothers who have been in the program are asked if they are willing to have women visit them who are postponing parenthood or who are pregnant. The new mothers are selected mainly on the basis of their willingness to share their child-care experiences. No inducement is required since the mothers have often participated in Maternal Role Practica themselves and are willing to provide others with a similar experience.

The visiting women observe, ask questions, practice child-care tasks, and experience the realities of ministering to an infant. Each woman makes as many visits to as many mothers as possible so that she may gain broader experience and practice those tasks that seem difficult. At office sessions or in group meetings the women discuss their reactions. For the prospective mother an additional benefit is that after her own baby is born, she has an experienced "friend of the family" to call upon when minor crises occur or when reassurance is needed.

Family Development Interviews

The early period of coping with an

infant is crucial in evolving patterns of family interaction. To explore a woman's emergent family life concerns, Family Development Interviews are held once a month for the first year of the child's life. A home visit is scheduled when the infant is 2-3 weeks old, and subsequent interviews are held at the office.

The interviews are designed to elicit the new mother's reactions to her family situation. The areas covered are concerns about adequacy in physical child-care regimens; emotional response to being a mother; reactions to the child; view of her husband as a father; changes in her marital relationship due to the presence of the child; role conflicts (i.e., career woman v. housewife, wife v. mother, etc.); effects of the grandparents' reactions to the baby and to her as a mother.

Approximately every 3 months a Family Development Interview is devoted in part to the infant's development, including questions on the infant's growth patterns related to feeding, sleep-wake intervals; frequency, time, and intensity of crying; physical mobility; social responsiveness, etc.

Videotape Playback Procedures

Prior to the birth of her child the woman is engaged in simulated mother-infant situations—first with a life-size doll and then with an infant. These situations project her into motherhood, and elicit observable maternal-role behavior and reports of self-feelings. These preparental "practice situations," the observations of the videotape playback, and discussions, provide conditions for the exploration of maternal orientations and expectations, the recognition of potential sources of difficulty, and the development of a sense of self in the maternal role.

During home visits a typical series of child-care activities, such as feeding, bathing, diapering, handling, comforting, and playing with the baby are recorded on videotape. Periodic playback of these sequences enables her to observe the infant's development and her evolving maternal behavior. The playbacks and discussions help the new mother plan and implement changes in her patterns of mothering.

Applicability of Procedures

The procedures have special applicability for women with particular reproductive-related problems: women with reproductive dysfunctions that cannot be explained in terms of somatic conditions; women who are unsuccessful in controlling their fertility as manifested in unplanned pregnancies in marriage and out-of-wedlock pregnancies; women considering adoption or artificial insemination; and women considering abortion or sterilization. With appropriate modifications, the procedures may be incorporated in services of prenatal and postpartum facilities, infertility and abortion clinics, and family planning programs. They may also be used as data-collecting strategies in studies of childbearing motivations and conflicts, childbearing decisions, and maternal behavior.

Condensed with permission from the *American Journal of Orthopsychiatry*, 42(3): 389-397, 1972. Copyright 1972 by the American Orthopsychiatric Association, Inc.

Reprints of original article from Mark Flapan, Ph.D., Family Development Research Unit, Division of Community and Social Psychiatry, Columbia University (address requests to 238 Ft. Washington Ave., New York, N. Y. 10032).

as the first menstrual period, and asks the woman to pretend that this is the day the event took place. She begins by saying "Dear Diary," and describes aloud, as though she were writing, the thoughts, feelings, and reactions precipitated by this event.

Other experiences may be when she first became aware of the differences between boys and girls; the time she first learned about or discussed the "facts of life;" when she obtained her first brassiere; her first awareness of sexual sensations; her first and subsequent love experiences; the first time she had sexual intercourse; when she was making the decision to get married; her first gynecological examination; and when she was deciding to have a child or postpone childbearing.

We do not assume that the Imaginary Diary conveys a completely accurate account of life-experiences. However, when a woman "writes" a diary relating to some childhood event, her tendency to view childhood experiences from an adult perspective is lessened. The language and tone are frequently appropriate to the age-period designated, indicating that the woman is transposing herself in time and is to some degree able to recapture her past experience. The Imaginary Diary minimizes the individual's consciousness of the interviewer. This is indicated by the fact that women frequently express surprise that they were able to reveal such intimate experiences with a minimum of embarrassment.

"Imaginary Letters" is used to explore interpersonal concerns or motivations related to childbearing. For example, a woman may be asked to "write" (actually to talk aloud) an imaginary letter to her mother, indicating that she has decided to have a child as soon as possible, or that she has decided to postpone having her first child for a given period of time. In writing the letter, the woman reveals the thoughts and considerations that have entered into her decision. She then pretends to be her mother and answers the letter in the role of her mother. The exchange of imaginary letters can be repeated with father, sister, friend, or husband.

Maternal Role Practicum

Prior to the birth of a first child, many women have not participated in the physical care of an infant and have little knowledge of the impact that an infant may have on their daily living. Mothers who have been in the program are asked if they are willing to have women visit them who are postponing parenthood or who are pregnant. The new mothers are selected mainly on the basis of their willingness to share their child-care experiences. No inducement is required since the mothers have often participated in Maternal Role Practica themselves and are willing to provide others with a similar experience.

The visiting women observe, ask questions, practice child-care tasks, and experience the realities of ministering to an infant. Each woman makes as many visits to as many mothers as possible so that she may gain broader experience and practice those tasks that seem difficult. At office sessions or in group meetings the women discuss their reactions. For the prospective mother an additional benefit is that after her own baby is born, she has an experienced "friend of the family" to call upon when minor crises occur or when reassurance is needed.

Family Development Interviews

The early period of coping with an

infant is crucial in evolving patterns of family interaction. To explore a woman's emergent family life concerns, Family Development Interviews are held once a month for the first year of the child's life. A home visit is scheduled when the infant is 2-3 weeks old, and subsequent interviews are held at the office.

The interviews are designed to elicit the new mother's reactions to her family situation. The areas covered are concerns about adequacy in physical child-care regimens; emotional response to being a mother; reactions to the child; view of her husband as a father; changes in her marital relationship due to the presence of the child; role conflicts (i.e., career woman v. housewife, wife v. mother, etc.); effects of the grandparents' reactions to the baby and to her as a mother.

Approximately every 3 months a Family Development Interview is devoted in part to the infant's development, including questions on the infant's growth patterns related to feeding, sleep-wake intervals; frequency, time, and intensity of crying; physical mobility; social responsiveness, etc.

Videotape Playback Procedures

Prior to the birth of her child the woman is engaged in simulated mother-infant situations—first with a life-size doll and then with an infant. These situations project her into motherhood, and elicit observable maternal-role behavior and reports of self-feelings. These preparental "practice situations," the observations of the videotape playback, and discussions, provide conditions for the exploration of maternal orientations and expectations, the recognition of potential sources of difficulty, and the development of a sense of self in the maternal role.

During home visits a typical series of child-care activities, such as feeding, bathing, diapering, handling, comforting, and playing with the baby are recorded on videotape. Periodic playback of these sequences enables her to observe the infant's development and her evolving maternal behavior. The playbacks and discussions help the new mother plan and implement changes in her patterns of mothering.

Applicability of Procedures

The procedures have special applicability for women with particular reproductive-related problems: women with reproductive dysfunctions that cannot be explained in terms of somatic conditions; women who are unsuccessful in controlling their fertility as manifested in unplanned pregnancies in marriage and out-of-wedlock pregnancies; women considering adoption or artificial insemination; and women considering abortion or sterilization. With appropriate modifications, the procedures may be incorporated in services of prenatal and postpartum facilities, infertility and abortion clinics, and family planning programs. They may also be used as data-collecting strategies in studies of childbearing motivations and conflicts, childbearing decisions, and maternal behavior.

Condensed with permission from the *American Journal of Orthopsychiatry*, 42(3): 389-397, 1972. Copyright 1972 by the American Orthopsychiatric Association, Inc.

Reprints of original article from Mark Flapan, Ph.D., Family Development Research Unit, Division of Community and Social Psychiatry, Columbia University (address requests to 238 Ft. Washington Ave., New York, N. Y. 10032).

Teaching Human Sexuality: The Use of Discussion Groups and Teaching Aides in a College Course

Eleanor S. Morrison

There is a challenge for teachers of family life and sex education to find ways of teaching and learning which emphasize the human in human sexuality and yet produce a solid foundation of research-based information. In a society with diversity of sexual value systems, the temptation is to focus on "the facts." Yielding to that temptation perpetuates the separation of the psycho-socio-personal dimensions of human sexuality from the intellectual understanding of them.

Readings, quizzes, and lectures have an important place in providing students with informational material which is needed. But there needs to be an opportunity for personal reflection, personal interaction, and confrontation with a variety of sexual value stances.

As a beginning, the Family and Child Science Department course at Michigan State University, "Human Sexuality and the Family," utilizes small peer group (six-person) interaction as one of its major components. The groups are seated together for all sessions, allowing the possibility that even on days of lectures, there may be time for interaction in the core group.

Reasons for Using Procedure

There are cogent reasons for the inclusion of a discussion component—without faculty intervention or presence—in a course on human sexuality. Among them are:

¶ The high priority of the peer group as a source of information and learning about human sexuality. Despite parent education and sex education efforts, research reveals that the major source of information (and misinformation) about sexuality is peers. A group of peers in a classroom is not identical with an intimate group of friends, but such contrived peer groupings have their usefulness. Even students who indicate reluctance to deal with personal concerns find the group helpful in counteracting sexual myths and misinformation.

¶ The importance of reflection on familial and personal "learnings" about sexuality and testing them against those of persons from different cultural and value traditions. The classic locus has been the "bull session." The design of this course is predicated on the assumption that a continuing group of peers who share a common background of readings, lectures, films, and speakers in addition to their interaction may preserve some of the best aspects of the bull session, enriched and corrected by accurate information.

¶ The paucity of opportunity for open communication about sexual matters. Despite the "sexual revolution" of the 20th century, there is a reticence about speaking of sexuality (in other than jocular or lewd terms). And there is little opportunity for men and women to reflect and speak seriously with peers about sexual matters outside of a "sexually loaded situation" in a bedroom or parked car. Development of ease in communication about sexual matters without seductive or embarrassed overtones is an important goal of small group interaction.

¶ A focus on the human dimension of sexuality. As a student "learns"

about human sexuality, he is dealing not only with information about gonads, coitus, and orgasm, but also with personal knowledge about himself, his sexual role, his style of interaction with his own and the opposite sex. This is not to dismiss the importance of the cognitive component of learning about sexuality, but to add to it the existential.

¶ The proliferation of diversity in sexual life styles. Beyond the physiological aspects of sexuality, there is a multiplicity of concerns on which there are differing convictions—homosexuality; pornography; autoerotic behavior; marital, premarital, and nonmarital contracts; sterilization, contraception, and abortion; women's liberation; sex and racism; diverse sexual practices; and ethics. Each student comes to the course with a value stance about sexual matters ranging from the methods and positions of coitus to interracial marriage. One function of the group is to bring values to the level of awareness by holding a mirror to the values of all the students, while opening doors into the value systems of others. The core groups are a maximum mix of men and women, married and unmarried, with diverse value positions.

¶ The ways in which human sexual functioning are tied to personal perceptions about self and others. Dealing with feelings and attitudes will not automatically occur because of a student's involvement in a small group, but the possibility is greater than in a lecture or plenary group format. The risk involved in exposing one's ignorance or attitudes is less in a group of six than in a group of one or two hundred.

Disadvantages

Some students enroll in such a course hoping for three easy credits, and have neither the motivation nor interest to work seriously. Some are threatened by the freedom and openness of a group, especially such a small one, and feel that there is little "learning" occurring. Others feel that sexuality is a private matter, and nobody else's business—peer or otherwise.

The contract to leave the groups free from faculty intervention has disadvantages for the faculty. One is relative ignorance of the interaction in the group. (If a group dies, fails to get off the ground, founders on apathy or conflict, a portion of the course may be meaningless for those students, and the faculty is unaware that this is occurring). The other is isolation from student interaction. In an area such as sexuality, it is important for faculty to be apprised of "where the students are" in order to design educative processes which help students look at personal, cultural, and intellectual assumptions.

Utilization of Student Assistance

To maximize the effectiveness of the groups, students are utilized as group facilitators and codesigners with faculty. These students are undergraduates who have taken the course and have demonstrated ability in group facilitation or interest in the subject matter, or graduate students interested in teaching human sexuality. Several student facilitators have preferred to be "untainted" by faculty roles, and have made no presentations to plenary sessions, nor participated in evaluation. They have maintained a facilitator-observer role rather than a teacher-leader stance. Other aides have adopted a more participative role, evaluating written assignments, serving as catalysts in group interaction, and giving directions for class interaction to the total class (a "teacher" or faculty role).

Each coordinator has responsibility for and relationship to one or two core groups. This responsibility has three facets:

Student-faculty intermediary—They perform housekeeping functions—keeping attendance, interpreting requirements and deadlines, receiving written assignments. They read work turned in by the group, so they can be apprised of a particular student's reading and critique of the reading—and then pass the work to the faculty. They relay to faculty gaps in understanding, needs for emphasis, as well as special resources within the group. They encourage evaluation of the course content and design and indicate their willingness to serve as conveyor of those opinions. Students are considerably less guarded with coordinators than with faculty in making critical assessment. The coordinators serve a "bridging" function in relaying to the faculty student opinion, conviction, and practice in the sexual areas with which the course is concerned.

Group catalyst or facilitator—Some groups need help to function productively. The coordinators serve in this capacity in a variety of ways: They provide the group with a "springboard" experience for launching into a particular subject-matter area. They help a group look at its own interaction and process to determine the difficulties. On rare occasions, they step in to become group leaders or catalysts. Mainly, they participate as a fellow student.

Joint course designer with faculty—The faculty and coordinators meet weekly for a seminar. Each coordinator chooses an area of course content which is his special area of responsibility. He formulates alternative teaching-learning designs to implement the subject matter in plenary sessions and in core groups. These proposals are tested in the seminar for effectiveness before use with the class. A variety of approaches is used—always with the aim of communicating content material and providing a way in which students can participate in response, critique, or elaboration of that material.

In a course focused on sexuality, it is doubtful whether the teaching-learning design will be the same for two terms. But the intention to involve students in their learning, to encourage use of their own experience and convictions, while expecting serious intellectual and academic effort, seems an important part of a humanistic educational focus.

Condensed with permission from *The Family Coordinator*, 21(2):173–176, 1972. Copyright 1972 by The National Council on Family Relations.

Reprints of original article from Eleanor S. Morrison, M.A., Litt.D., Instructor, Department of Family and Child Sciences, College of Human Ecology, Michigan State University, East Lansing, Mich. 48823.

Toward a New Feminine Psychology

Natalie Shainess

A generation back, the most dreadful accusation that could be leveled at a woman was that she was aggressive. She was also that monster, that Medusa who suffered from "penis envy." It led women—and society—to ignore something more dreadful: the aggressive man, who has led culture after culture into war—an institutionalized form of murder, which is antithetical to human survival.

Am I going to talk about men? Not really. But this serves to say that the phenomenon of scapegoating has led men—and women—into denials of their problems, while being clear—on the alleged problems of others. Women, an underprivileged subgroup of our society, vulnerable because they live interspersed within that society without the cohesive possibilities of a separate group, became model Uncle Toms—or Aunt Janes—until Women's Lib came along.

The "penis envy" concept was one observation—and theory—of Freud, who perceived this envy, but was inattentive to its cultural aspects. Freud felt there was an instinctual basis for penis envy, although he noted that some girls suffered in greater degree from "masculine protest." Aggressive behavior in women was considered to be the hallmark of this condition. At times, it may be. But was this envy the result of instinct?

In spite of Freud's recognition that the male and female organs derived from the same embryonic "anlage," on which he based his concept of bisexuality, he ignored this, and felt woman was born defective—lacking a penis. She conceived of herself as wounded. She felt castrated—psychologically as well as physically. Although observing that "social convention often influenced women to be passive," he felt that woman was born passive, narcissistic, masochistic, more prone to jealousy, having a weaker superego or conscience than man.

He compensated women for this pitiable and negative view, equating the production of a child with the "gaining" of a penis. In motherhood, a woman was restored to psychological balance, especially in producing a male child. He observed correctly that women have a dual sexual role—being mate, and then mother. He noted an interrelationship between the two, and that the second aspect depended upon the first.

Freud's view of women as passive in everything precluded her having any place in the outer world. His position was strange in the sense that he was generous and accepting of women as colleagues, although apparently they never figured in the inner politics of his psychoanalytic discipline. The fact that psychoanalytic theory was based on the maturation of libidinal stages, all of which were "instinctual," led away from recognition of the cultural, and the interpersonal—the effect of what went on between people, in the organization of experience.

In a paper called "Feminine Identity and Mothering," I pointed out that there are "nodal points" in every girl's development. These are connected with the girl's reproductive life, and in many ways make the girl's reproductive life and its inner psychological representations, colorful and dramatic. The points are the menarche, the development of breasts—(a development overlooked by Freud, to

the best of my knowledge), defloration, pregnancy, delivery, the larger rhythms of pregnancy weaving through the smaller rhythms of menstruation, and the menopause—a condition which need not be accompanied by psychological problems.

I observed that while some of these occurrences might be painful, the implication that women enjoy suffering had little validity. Of course, when deprived of attention or more positive interests, individuals learn to derive "secondary gain" from suffering. These nodal points have psychological components—the felt aspects of the biological experience. But even more, they are centers of certain types of interpersonal transaction. In a study on menstruation, I demonstrated how menstrual problems are largely determined by the mother-daughter relationship and interaction.

Seen sequentially, these nodal points represent a schema of woman's reproductive life. The psychology surrounding them is the only psychology which can be called "feminine psychology." From a different perspective, one could say that feminine psychology is that psychology which relates specifically to woman's mastery or difficulties in relation to her reproductive function, in all its vicissitudes. This leads into a serious and difficult issue: that of abortion.

The abortion issue is central to feminine psychology, because it involves the question of mastery of reproductive life. Psychiatrists and psychoanalysts in the past have derived their thinking from theological positions, or demands of the culture, not from the concerns and needs of women or from the vantage point of what is best for society. Insistence that women are emotionally damaged by abortion, feel guilt, etc., had little justification in reality to those who could see more penetratingly than to accept surface manifestations. There is a great deal more that could be said, but in this résumé I will include it as one psychological nodal point of feminine reproductive psychology, which may occur, whether through the experience of abortion, or through the experience of refusal of abortion.

I do not attempt to reconcile the two positions: Theological attitudes have their validity; psychiatric impressions theirs. Women cannot be free, cannot strive for mastery, cannot have a sense of self-assertion, if they do not have the ability to choose whether or not and when to have children, just as they choose whether or not and when to marry. Abortion is a right of women—a backup against failures of contraception. Wanted children are more likely to be loved children, produced by a confident mother.

Now I turn to another aspect of the problem, gender role," "gender identity," "gender-role stereotyping." Considering gender identity—it is the sense of being a woman. The positive sense of gender, which is one aspect of the positive sense of self, contains a feeling of "belonging" to the sex, of pleasure and of pride. It means accepting the different reproductive phases, and especially the occurrence of (willing) motherhood with pleasure. It implies accepting the heterosexual relationship eagerly (with a carefully selected person!).

Gender role relates to society's concepts of what is fitting and allowable activity for either sex; gender-role stereotyping suggests fixed ideas about what is "proper"—especially for women. Here, of course, is what occasions all the outcry for equal rights, and equal opportunities—an outcry to which I lend my voice. It seems

strange that if women are perceived as defective or handicapped, masculine assistance is not there in ways other than opening doors. Undeniably, there are some jobs demanding physical strength, to which men are better suited. Intellectual strength is equally divided, and society must provide doors equally open, to all. The divisions of labor which related to a time when man was tied to the soil—the yeoman period or frontier life—no longer have validity.

In considering gender, are there any "biological" distinctions? Are there constitutional differences? There are differences between men and women in the psychic representations of their sexual, endocrine, and reproductive biology. Constitutionally, in relation to temperament, I believe women are more placid. This runs counter to the concept of women as hysterical, wildly emotional creatures. This view is the result of societal forces. Women have always been skilled and enduring in detailed work —they show greater patience, and comparison with lower animals reveals that, for example, it is the bull or stallion which is skittish, while the mare and the cow are more placid.

Differences in size and muscular endowment create somewhat different problems in civilization as well. Although psychic representations of the sexual role are largely lost in our culture, there seems to be a way of characterizing masculinity and femininity which reflects the biological sexual difference. If there is a quality which can be considered feminine, it is that of receptivity. But it need not be considered a passive quality. It represents the taking in of the penis in sexual intercourse, the "taking in" and envelopment of the fertilized egg, the "surrounding of the child" with supportive, nurtural care. It can represent a quality of "openness" in intellectual and work endeavors, and of "wifeliness" as well. This quality is very noticeable in some women—especially those we consider "maternal."

The masculine equivalent is the quality of being penetrating, whether it is to penetrate the woman in sexual intercourse, more daring in penetrating into the world and now outer space, or in work, where self-assertion (not aggression!) may come more naturally. Let me stress that there are so many other—and socially determined—variables, that it is rare for these specific qualities to show through.

In the light of current concern with sexual matters, I want to single out sexual problems in women. Fifty years ago, it was an unusual woman who was not "frigid," or more accurately, anesthetic. This was considered to be a normal aspect of woman's passivity. Yet the medical literature contained a plea by women to husbands that if the men were kinder, more considerate, and more tolerant, the women believed that they could overcome their sexual problems. It is interesting to find in the literature today efforts at treating women for frigidity through trying to get them to conform to their husbands' demands. This suggests a misunderstanding—and mistreatment—of women. While it takes two to make things go wrong in any close relationship, one might ask how it is possible to expect enthusiasm in bed of a woman whose husband has been stingy and ungiving about money, upbraided her for not having dinner ready on time, and taken a swipe at her, to boot! Or one whose timing for sex is never attuned to hers. I am not suggesting that women have not had their faults, but here is one aspect of the problem.

Today, of course, sexual matters have swung to the opposite extreme —with unfortunate results. Every woman cannot have an orgasm; this is a complex matter, and I believe that women are hurting themselves with the new aggressiveness they are displaying in sex. They cannot be penetrating, but they can be actively receptive. They can give out signals encouraging the man. In trying to exchange roles with men, they are interfering with masculinity, and hurting their own best interests. Of course, there is confusion today, as we have new, allegedly scientific sex experts, who are the product of a mechanistic age, and dispensers of alienated pseudo sex. Authentic sexual response cannot be obtained by mechanical means, and once again, women are the losers in not asserting *themselves.*

Some readers may be feeling that something has been omitted. Nothing has been said about early experience, other than that related to gender, or about relationships with significant adults, about developmental stages, or even that drama of adolescence, the oedipal struggle. And for good reason. These relate to the developing *human being,* not specifically to feminine psychology. Perhaps with a slight qualification, as a neo-Freudian who sees the oedipus complex as a power struggle between parent and child, of particular significance where parents have refused to let the child individuate and mature, I see the mother as the primary person from whom the girl must free herself. This could be included as part of developmental feminine psychology.

I have simplified—perhaps oversimplified—in order to bring out the fact that there are limited areas of difference in the psychology of men and women. How girls are received into their family and treated is influenced by their sex, but depends more on the qualities and attitudes of the parents than anything else. How women respond to the sexual vicissitudes of their lives, and to the options life presents, depends in large measure upon the more general aspects of their experience as children.

Men and women are all human. They would mutually benefit, if walls and barriers were not placed in their paths. Virginia Woolf, in *Orlando,* tried to show that men and women share all human traits, abilities, and potentials. In describing a reaction of the lovers, she said: "each was surprised at the quickness of the other's sympathy, and to each it was a revelation that a woman could be as tolerant and free-spoken as a man—and a man as strange and subtle as a woman."

Condensed with permission from the *Notre Dame Journal of Education,* 2(4):293–299, 1972. Copyright 1972 by the University of Notre Dame.

Reprints of original article from Natalie Shainess, M.D., Lecturer in Psychiatry, Columbia University College of Physicians and Surgeons, 630 West 168th Street, New York, N. Y. 10032.

The Sexually Oppressed

Harvey L. Gochros

Every society regulates and molds the expression of biological sex drives. As a result, a spectrum of acceptable and encouraged sexual behavior emerges in each society. This spectrum shifts over time: Formerly forbidden behaviors become permissible, while formerly approved behaviors are rejected.

At any one time, this spectrum determines who might have sex, at what age they can begin, and when they should stop; the age, sex, number, and characteristics of persons with whom they can have sex; where and under what circumstances sexual activities can occur; and which sexual acts are condoned, including which parts of the body and, in coitus, which position.

There are few aspects of a culture about which people tend to be as ethnocentric as sexual behavior. Society has little patience with individuals who exhibit different sexual behavior in other cultures or within its own. Indeed almost every State has laws aimed at maintaining this spectrum.

The Sexual Elite

The regulation of sexual activity produces sexual elites, who are relatively free to express themselves sexually, and the sexually oppressed, who are restrained from sexual fulfillment or subject to dangers, contempt, ridicule, or compromises if they are to meet their sexual wishes.

In our society the sexual elite reflects a bias toward reproduction. Sex is permissible primarily between individuals in situations that could lead to socially desirable pregnancies. Since most sexual activity does not and should not lead to pregnancy, proscriptions against nonreproduction-oriented sex are irrational as well as destructive. Nevertheless, these proscriptions persist.

The sexual elite is best represented by the hero and heroine of *Love Story*. The hero is a young, handsome law student, the heroine a young, beautiful music student. They fall in love, engage in premarital intercourse as an expression of their love, and marry. She uses four-letter words but is underneath a nice girl who would not dream of marital infidelity. They have fun and never stop loving each other until she dies an elegant death. Neither feels much love or affection for anyone else except her father, who is sweet but passive. One might assume the hero is always potent, the heroine achieves multiple orgasms, and they never need Kleenex. They consider genital-to-genital intercourse in the missionary position culminating in simultaneous orgasms the normal conclusion of every sexual activity that occurs 2.7 times a week.

This is obviously a stereotype maintained by the white middle class. There are, of course, sexual spectrums in other American subcultures, portrayed in films such as *Easy Rider* for the counterculture and *Sweet Sweetbacks Badass Song* for urban ghetto blacks.

Since the ideal sexual model varies, it is desirable for social workers to inventory and reevaluate their attitudes, prejudices, and behavior related to their own as well as other sexual spectrums before they can be effective in helping with sexual problems.

The problems of the sexual elite are

relatively well attended to. The techniques for dealing with these problems could be improved, but at least we are paying attention to them. And the popularity of such books as *The Sensuous Woman* shows that our society is ready to start enhancing sexual pleasure for the elite, and not just condone it.

There are subgroups of the elite who would profit from social work attention:

Young married couples constrained in their sexual behavior by taboos, who cannot communicate their sexual wishes and needs and believe the only "normal" sexual behavior involves the dive for the pelvis or choreographic sexual dexterity and intercourse culminating in powerful simultaneous orgasm.

Adoptive couples and their adolescent adopted children whose relationships and self-image may be colored by the couple's infertility, the natural parents' perceived promiscuity, and the question of the adolescent's inheritance of the natural parents' "antisocial" behavior.

The widowed and divorced, who no longer find a road to socially acceptable sexual fulfillment.

Couples who seek revitalization of their marriage and their sexual and personal identity through swinging but find new problems.

Despite the sometime painful, pervasive problems of the sexual elite, social workers, because of their values, social commitments, and constituency, might be more useful by addressing themselves to the sexual problems encountered by the sexually oppressed. These groups whose sexual rights and outlets have been limited or completely withdrawn, have had little attention paid to their problems by the helping professions.

There are many such groups. They include adolescents with strong—perhaps the strongest of all—sexual needs, whose range of sexually acceptable behavior is circumscribed but increasingly vague; the handicapped (such as the paraplegic and the blind), whose condition prevents them from assuming the roles associated with sexual fulfillment; the mentally retarded, who go through life not smart enough to be permitted sexual fulfillment; unmarried adults, whose sexual needs are rejected or ignored by society, despite the playboy image of the happy swinger; women, who have come a long way but still suffer from sexual ambivalence; and the poor, who have almost everything against them as far as sex goes, from poor nutrition and crowded housing to restrictive welfare laws. This article focuses on four large groups of the sexually oppressed for whom the social worker might have a great impact: the aged, homosexuals, hospitalized mentally ill, and imprisoned.

The Aged

It is difficult to perceive the elderly as sexually viable. But as people live longer and maintain better health, it becomes evident that sexual interest and capacity can be sustained into the seventies and beyond.

A study which investigated the effects of age, sex, and marital status on the sexual behavior of men and women between 60 and 90 years old, found that age and sexual activity were not strictly correlated. While age-related infirmities and physical illnesses affected sexual behavior, the incidence of sexual activity was maintained at 50 percent during the early sixties and from 10 to 20 percent at age 80. Sexual activity can be a rewarding experience and a need for men as well as women in their

later years, if circumstances permit.

Circumstances, however, do not always permit. Many old people are widowed and isolated. Some have untreated physical conditions that make sexual satisfaction difficult. Some use advancing age as an excuse to terminate a relation they have never enjoyed; some perceive an encounter with impotence as a signal for termination of sexual relations and avoid subsequent attempts for fear of embarrassment. But even when there is interest and opportunity, cultural taboos prevent sexual experience. Society does not take well to grandparents cavorting in bed. Indeed, the expression "dirty old man" connotes disgust and disapproval of those interested in sex beyond 40.

Physiological changes compound taboos and lack of opportunities for a satisfying sex life. As a woman becomes older, her vaginal walls become subject to irritation, while the man takes longer to achieve an erection that is not as firm as when he was young. Ejaculation may not come as quickly as it did. Yet those physiological problems need not prevent some form of sexual activity. Medical consultation and treatment are useful. Social workers also can help. There are some homes for the aged, for instance, that encourage romance and remarriage and provide privacy.

Social workers can assist elderly, isolated people to develop contacts through clubs and organizations. Sex education may be as useful for the aged as for the young. For those living with a sexual partner, we can help destroy the myth that coitus is the only vehicle for sexual expression and advocate revision of sexual patterns such as position and timing. For example, sex in the morning is often preferable to avoid fatigue interfering with sexual activity.

While talking about sex may be alien to many aged clients, the social worker can attempt to explore sexual needs and activities and help the aged meet these needs through reestablishment of interpersonal sexual activity or through masturbatory activity. We might even consider marital reform. Such reform would acknowledge the greater number of aged women than men and legalize polygamous living arrangements for those past 65.

The Homosexually Oriented

It may well be that confirmed homosexuals will in some ways become the blacks of the 1970's. Their problems have been ignored or misunderstood and their rights denied. They are substantial in number: An estimated eight million men and women are exclusively homosexual, and untold millions live in the twilight zone between exclusive heterosexuality and exclusive homosexuality. The majority remain invisible, preferring to keep their homosexual wishes or behavior unknown to others.

Social workers have not shown concern for this group proportionate to its size and the complexity of its problems. Indeed, many social workers feel discomfort in working with homosexuals. This is particularly true of men whose sexual identity is threatened by being in what is thought of as a female-oriented profession.

Even if the worker overcomes revulsion or fear of guilt by association and tries to be helpful, he approaches homosexuals with the goal of "conversion." Regardless of the nature of the problem, he wants them to change their sexual orientation to heterosexual objects. Putting aside the issue of whether such a change is therapeutically probable, the fact re-

mains that many homosexually oriented adults do not choose to switch. To them, switching would be as unthinkable and undesirable as it would be for a heterosexual, and they resent this bias on the part of counselors.

They also resent the perception of homosexuality as an illness. One might question the imputation that a deviation from norms of sexual orientation implies a pathology of the total personality. Indeed I have treated many people with homosexual orientations who lead rewarding, constructive, and pleasurable lives, disrupted only by problems society creates for them.

The homosexual lives in a secret world. This secrecy leads to many dysfunctional aspects of life: lack of opportunities to meet a wide range of potential partners; difficulty in establishing and maintaining long-lasting relationships; fear of arrest, loss of jobs and social acceptance, and blackmail.

Many of the homosexual's problems are similar to those who bear any other social stigma. This is not a stigma of their own choosing. But the homosexual suffers the consequences of these stigmas that can, but do not necessarily, include self-hatred, guilt, seeking out others with similar stigmas, rejection by family, striking out against an unjust world, alienation, and relative social isolation.

It is with the consequences of these stigmas and the problems of living a satisfying, productive life that the social worker can be of most help. The nature of social work services to the homosexually oriented can be as diverse as the individuals who are so oriented, the unique characteristics of each situation, and the attitudes toward and resources for the homosexually oriented in the community in which they live. The social worker can assist the homosexual client decide whether to remain in his community or move to a community with more opportunities and safety.

There are other useful roles the social worker can perform:

He can help a young man make the complex series of decisions associated with "coming out" (revealing his orientation) and deal with his complex reactions to the process.

He can engage in a form of marital counseling for a crisis in a long-lasting and sound homosexual relationship.

He can help a young engaged man with a bisexual history evaluate the probabilities of marital success and decide whether and how to tell his intended wife.

He can help a middle-aged woman work through her guilt about her homosexual relationships.

He can find a more desirable setting for a community of homosexuals than "gay" bars, steam baths, and public toilets.

Whatever the task, the worker must be willing to accept the sexual orientation of the confirmed adult homosexual and work with him on the consequences of that orientation.

With adolescents the situation may be different and more complex. While some argue that sexual orientation is fixed by adolescence, the evidence is far from conclusive. If the adolescent wishes to change to a "normal" sexual orientation, the worker should help develop the adolescent's heterosexual orientation. This can perhaps be achieved by approaching the adolescent's fear of heterosexual contacts. The worker can program increasing approximations of intimate heterosexual activities that have a high probability of success.

Current dysfunctional parental influences, if any, should be explored and altered when possible. Such an

approach is especially useful in those cases in which a young unmarried adult appears in a panic, fearing he is a homosexual as a result of heterosexual anxieties or failures. Often he connotes his discomfort with evidence of homosexuality, even if there has been little sexual interest in people of his own sex.

The social worker has the responsibility for helping homosexuals who are not interested in conversion to achieve as much satisfaction in life as possible and to deal with the legal, vocational, social, and interpersonal problems that result from their orientation. Further, the social worker should work to alter societal attitudes, sanctions, and reform laws to ensure that homosexuals' rights as human beings are preserved.

The Hospitalized Mentally Ill

Many years ago visitors to institutions for the mentally ill noted that chronic psychotics seemed to masturbate openly and regularly. As a result, the fallacy developed that if those who are mentally ill masturbate, then masturbation and "preoccupation" with sex lead to mental illness.

Another myth developed that those who are adjudicated mentally ill are sexually dangerous and incapable of maintaining sexual or interpersonal relationships. This has been compounded by the fear that sexual activity among the mentally ill will produce mentally ill children who will become tax burdens.

Our treatment of the mentally ill contributes to the reality and the myth of these assumptions. Many hospital patients have minimal privacy and little to do that is satisfying other than masturbation. And if they are deprived of heterosexual opportunities, they become preoccupied with sexual thoughts and choose aggressive or deviant sexual activities.

Sexual rights are one of the first civil rights that the mentally ill lose. Society's fear of behavior labeled as mental illness, as well as sexual inhibitions, lead us to treat the mentally ill in a sexually repressive manner. A humane treatment would lead to attempts to normalize heterosexual opportunities, including efforts to maintain normal sexual, as well as emotional, ties with spouses and other opportunities for informal contact between the sexes.

The sexual problems of the hospitalized mentally ill are similar to those experienced by the imprisoned. These problems add to questions about the therapeutic value of confining most diagnosed "mentally ill" persons in institutions.

The Imprisoned

Once in a while, an episode reminds Americans that in every State there are thousands of caged men and women hidden from public view. Although sexual deprivation is much on the prisoners' minds and is often at the core of prison violence, few "rehabilitation" programs do much about it.

The attitude seems to be that the imprisoned deserve punishment and that one component of a punishment program is to deny them heterosexual opportunities. Few American prisons have developed programs that enable prisoners to engage in heterosexual intercourse with their wives or girlfriends. There is no American prison that approaches the Mexican system of allowing prisoners' wives and children to live with them at State expense.

The exception is the Mississippi State Penitentiary which has had a policy of "conjugal visitation" and furloughs outside the prison since

1918. California prisons have begun experimenting with a similar program. Conjugal visits provide for wives to visit their husbands in relative privacy with acceptance of the fact that intercourse is likely to occur. The furlough allows the prisoners to pursue their sexual and other desires in the community .

Besides the issues of human rights, there are reasons why conjugal visits and/or sexual furloughs might be desirable: They could help keep marriages intact, reduce the consensual and forced homosexual behavior that results in prison violence and difficulty in readapting to the outside world, reduce sexual tension and make prisons a more tranquil place, and support sexually appropriate role identification.

There are arguments against conjugal visits. Conjugal visits emphasize the physical aspects of sex and marriage. They would not benefit unmarried prisoners, female prisoners, or homosexuals. They complicate security procedures and cost money, and money is not readily available for correctional programs. Taxpayers might object to subsidizing the sexual activities of prisoners. They could result in pregnancies and more babies for public funds to support. They go against society's urge to punish offenders.

These objections are peculiarly American. Canada, Mexico, and many European countries permit conjugal visits and the sexual furlough. If social workers and other professional groups took a more active role on this issue, there would be more humanity in prisons.

The problems posed by the lack of heterosexual opportunities and the homosexual rapes and violence are constantly confronting prison officials and correctional social workers. All too often those who work with prisoners remain silent and try to help prisoners adjust to this type of institutionalized deviance. Such attempts strain social work treatment approaches and values. The problems of contemporary prison systems are broader than sexual deprivation. The provision of conjugal visits has its drawbacks and may make prison life seem bleaker when those visits are over. But this innovation could serve as one step toward reforming our total penal system.

Condensed with permission from *Social Work*, 17(2):16–23, 1972. Copyright 1972 by the National Association of Social Workers.

Reprints of original article from Harvey L. Gochros, DSW, Visiting Professor of Social Work and Public Health, School of Social Work, University of Hawaii, Honolulu, Hawaii 96822.

The New Impotence

George L. Ginsberg, William A. Frosch, and Theodore Shapiro

Rapid changes in mores may be reflected in changes in psychiatric symptomatology. Young men now appear more frequently with impotence, and young women more frequently complain of initial impotence in their young lovers. This may be related to changed attitudes toward premarital sexuality, particularly among women.

The "average expectable sexual behavior" of the adult woman in middle-class American society has changed. The standard of wedding-night virginity prevailed well into the 20th century, and a myth separated women into good and bad with respect to their premarital sexual behavior. Many a woman viewed intercourse as something inflicted upon her by her mate, and her responsibility consisted of not denying him his rights. Advances in medical and social science provided the means by which emphasis on equal sexual rights for women have now become important. Women seek and expect orgastic release. We suggest that these changes have consequences in the structure and manifestations of neurotic phenomena. By breaking the former ecologic balance in society, a disequilibrium has been created, leaving its mark on the male partners of these new women.

Our observations of impotent young men suggest that this trend is a significant etiologic factor in understanding their disturbing and anxiety-producing impotence. While impotence has always existed, it now takes on an additional form. Sociological study is needed to know if there is an absolute increase in the complaint, but clinical study can suggest some avenues for such a sociological approach. Moreover, clinical study of a manifest symptom provides an avenue to understanding intrapsychic conflict which may have been obscured by socially approved rationalizations. While most depth analysis focuses on intrapsychic and familial determinants, the larger social context is also an important factor in falling ill.

Case 1—A 19-year-old student complained that fear of losing his erection had resulted in social inhibition with women. Following a period of pleasurable sexuality including petting, his girl friend had suggested that their sexual practices were immature and that coitus was more appropriate. He ejaculated prematurely and then was impotent.

Case 2—A man in his mid-thirties was referred after urological examination revealed no organic basis for impotence. The patient felt that his problems resulted from lack of experience. He claimed inadequate time to develop a lasting relationship with a "good girl," but sought out prostitutes. Justifying his insistence on fellatio, he said that not only did he avoid infection (sic) but he also rationalized it as permitting prompt return to the major pursuits of his life. He married in his early thirties because he felt it was expected of him. Until his wife's demand that he perform sexually, he was able to avoid his anxiety at confronting the female genitals and his own castration anxiety.

Case 3—A man in his early twenties entered treatment because of recent impotence. After the first two dates with a young woman, he felt that she expected him to approach her sexually. When she responded vigorously, he interrupted with the excuse that her roommate might return. He then no longer felt able to avoid sexual contact and invited her to his room. When he attempted coitus, he ejaculated immediately after intromission and apologized. A second attempt ended because he could not sustain an erection. When the failure was repeated on their fourth date, his partner berated him. In addition, she

was unable to achieve orgasm when he practiced masturbation on her. She claimed this was unusual and tacitly blamed his insufficiences.

Formerly patients with impotence were, for the most part, married men who withdrew sexually from their wives after a period of successful sexual functioning. They complained that the excitement had passed and their wives no longer provided variety in sexual practices. Impotence was accompanied by minimal anxiety. They usually had fantasies about the secretary at work, the girl next door, etc., and felt confident that novel objects or practices could revive their interest. This conviction prevented major anxiety and resulted in relative indifference to their wives' plaints.

A second type of impotence accompanied by more anxiety is seen in younger men of borderline disposition or with a larger component of latent homosexual or polymorphously perverse attitudes. Hostility to women and a strong degree of castration anxiety mark the underpinnings of their personality.

Currently young men describe failures occurring early in their relationships. Following such failures they become preoccupied with its meaning to their manhood. They withdraw or venture into counterphobic attempts to regain self-respect.

When we explored these sexual failures, we found a common male complaint: Newly freed women demanded sexual performance. The male concern of the 1940's and 1950's was to satisfy the woman. In the late 1960's and early 1970's, it seems to be "will I have to maintain an erection to maintain a relationship?" This idea is permeated with feelings of "who calls the shots" and "who is sex for." There is a reversal of former roles: The role of the put-upon Victorian woman is that of the put-upon man of the 1970's. Inhibited nonorgastic women can hide their lack of response, but men without erect penises cannot feign intromission. This challenge to manhood is most apparent in a sexually liberated society where women are perceived as demanding satisfaction from masculine performance.

Such newly freed women might say, "So be it—let the chips fall where they may." Women's sense of exploitation, however, often results in retaliatory rage and distortion of many worthwhile libertarian and equalizing aims. Unconscious transmission of feminine revenge by an aggressive manner and overassertiveness may enhance a man's castration anxiety with consequent fear of the vagina. This must be seen in an adaptational and social framework rather than as a purely psychological and particularly intrapsychic phenomenon.

Although for some the new "sexual freedom" may indeed be liberating, for others it merely induces different symptoms rather than improved mental health.

Condensed with permission from the *Archives of General Psychiatry*, 26(3):218–220, 1972. Copyright 1972 by the American Medical Association.

Reprints of original article from George L. Ginsberg, M.D., Department of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, N. Y. 10016.

Behavioral Factors in Non-Coital Methods of Contraception: A Review

Barry L. Borland

Methods by which family size is limited are different from those used prior to 1960. The reduction of reproduction rate in the U. S. has been associated with a shift from reliance on coital methods of contraception such as douches, condoms, withdrawal, and vaginal diaphragms, to noncoital methods—oral contraception, intrauterine devices, vasectomy, and tubal ligation. At the same time, controversy has arisen as to possible adverse physical and behavioral side effects as well as to the religious issues surrounding their use.

Vasectomy

Vasectomy, male sterilization, was first performed in the U. S. in 1897, but only within recent years have males voluntarily chosen vasectomy as a method of contraception. Studies of this procedure have demonstrated that it is safe and effective. With larger numbers of persons requesting the procedure, studies have focused on psychological or behavioral effects.

Motivating factors—The principal reasons given by men involved personal and practical considerations. Males requesting this procedure differ appreciably from males in the general population in that they have more education and a higher level of occupation and income. Despite their ability to obtain more expensive forms of contraception, these men seem motivated toward vascetomy, to the extent that many sought it without the approval of their physicians.

There is evidence that marital or sexual satisfaction is a consideration. In one study, the majority of the men were unsatisfied with their frequency of intercourse. These men evaluated their marriage less favorably than a control group whose wives were taking an oral contraceptive. Wives of husbands who chose vasectomy tended to be less responsive sexually, less experienced with a variety of orgastic techniques, and less willing to take contraceptive responsibility than wives choosing an oral contraceptive. These findings suggest males may choose a vasectomy to improve their marital or sexual satisfaction and that choice of contraception method may be determined, in part, by relative sexual satisfaction of the marital partners. However, more than half the men state their decision was based on distrust of other methods or on pleasure criteria. When vasectomy men were asked why they, rather than their wives, took contraceptive responsibility, the majority stated this entailed less physical trouble for themselves or that their wives were unable to obtain their preferred method.

Behavioral response—Vasectomized males overwhelmingly endorse vasectomy as a safe, convenient, and satisfying method. Still, adverse emotional effects have been attributed to this procedure with enough frequency to warrant attention.

Studies of effects of vasectomy were conducted on 42 couples over 4 years. Results were compared with a control group in which the wife was taking an oral contraceptive. At the end of this period 37 of the husbands were a part of the study group. Measures used to evaluate psychiatric and psychological status consisted of struc-

tured interviews, rating scales, and psychological tests. One year postoperatively there was increased dysphoria and emotional disturbance among some members of the study group. Fifty-eight percent evidenced minimal or no overall change. Forty-five percent demonstrated behavioral change in an unfavorable direction. The difference between those showing favorable and unfavorable change was identified by the hypochondriacal scale of the MMPI. The subjects with marked negative change also scored higher on the masculinity scale than all others, preoperatively. These results suggest that men who have excessive concern for their health and those who question their masculine effectiveness are likely to experience an adverse psychological reaction for at least 1 year postoperatively.

Preoperatively, no psychological differences were found between men in the vasectomy and control groups. However, at the end of 4 months, the extent of change was greater for the men who chose vasectomy than for those who did not. Vasectomy men emphasized masculine role behavior more strongly, their wives assumed a more compliant and complementary role in relation to them, and both assumed a more responsible and solicitous role toward their children. At the end of the 1st and 2nd years, vasectomy males seemed more socially ascendant and revealed more masculine interests, but they and their wives seemed more anxious, more vulnerable to effects of imagined or real physical ailments, and less socially conscientious and conforming.

Despite the findings that clinical evaluations of vasectomized males were less favorable after 2 years, men selecting that procedure were enthusiastic about vasectomy. And despite the less favorable psychiatric and psychological evaluations of the vasectomy couples, these differences were not excessive and did not indicate any widespread psychological deterioration on the part of the vasectomy couples.

Differences between vasectomy and nonvasectomy males were not so apparent after 3 and 4 years postoperatively. Essentially no differences were noted in psychiatric and psychological status between the vasectomy and control group. Vasectomy males who did show negative change at the end of 4 years were primarily those who scored high initially on the hypochondriacal and masculinity scales of the MMPI.

Sexual response—Although some men may select vasectomy as a means of improving sexual or marital harmony, there is contradictory evidence as to whether this objective is achieved. Findings of one study indicate no change in couples' ratings of their marital satisfaction over a 4-year period. But longitudinal studies of vasectomy couples indicate that, despite the older age of vasectomy males, their coital frequency was as high or higher than that of males whose wives were taking the pill. Thus, it cannot be said with certainty that sexual or marital satisfaction is increased following vasectomy, even though coital frequency does increase.

Although there has been concern that noncoital contraception promotes extramarital relationships, no studies indicate this has been a consequence. Vasectomy and oral contraceptives have been linked with continued or increased use of noncoital orgastic techniques, however. Even though couples in the past rationalized their use of these techniques on the basis of avoiding pregnancy, this assurance did not affect their use. These findings suggest that effective birth con-

trol does not directly affect desire to engage in noncoital orgastic activities. A more likely explanation is that the young, innovative, and somewhat nonconformist nature of these couples influences their desire for these kinds of activity.

Oral Contraception

Since 1960, ovulation-suppressing drugs have become a popular method of contraception. Although 16 percent of all women between ages 20 and 45 were taking "the pill" in 1965, these women differed from the general female population in terms of age, formal education, socioeconomic status, and number of years married. In 1965, 30 percent of married women under age 25, but only 63 percent of those over 35 had used the pill. Similarly, more than 25 percent of women married less than 5 years were using the pill, but only 11.1 percent of those married more than 5 years were using the pill. Within each 5-year age group between 20 and 45 years, the proportion of women using the pill increased as the level of their education increased. Urban Protestant women whose husbands have a white-collar occupation and are in the top income brackets are most accepting of the pill.

Motivating factors—Prolonged use of the pill appears to be based on social and psychological characteristics of the woman as well as her husband. Women who use the pill have a high level of social or interpersonal skills, as well as emotional stability. There is evidence that these women are more responsive sexually than others, and more willing than their spouses to assume responsibility for achieving social and family goals.

In a 4-year study of 39 couples using ovulation-suppressing drugs, the issues of which spouse should be responsible for contraception and who may be the prime beneficiary of the sexual act were more important than the question of how severe side effects might be.

Women who continued using oral contraceptives differed from their husbands, as well as from women who did not continue their use, with regard to their greater sense of family responsibility and effectiveness in achieving social goals. Husbands of wives who took the pill over a prolonged period were less dominant and more socially conforming than husbands of women who did not continue its use. Women are less willing to take contraceptive responsibility if they feel sexuality is of primary benefit to the husband and if the husband is more willing or capable of assuming marital or family responsibilities.

One study dealt with perceptions of various procedures by couples choosing vasectomy or ovulation-suppressing drugs. In general, the pill was evaluated as easy, convenient, comfortable, unembarrassing, refined, feminine, inexpensive, and uncommon.

Studies of ovulation-suppressing drugs stress their effectiveness in allowing the user to control fertility, promote freedom from fear of unwanted pregnancy and allow the couple to enjoy sexuality fully and spontaneously. At the same time, nearly all studies mention possible adverse behavioral or psychiatric symptoms as a consequence of use of this method of contraception.

Behavioral response—Studies of effects of oral contraceptives indicate mental or behavioral responses attributed to the use of oral contraceptive agents, but results differ according to whether the research was conducted under a prospective or retrospective design. Retrospective studies tend to

identify behavioral or psychiatric symptoms attributable to the use of oral contraceptives to a much greater extent than do studies using a prospective design. In a retrospective study it was found that more than half the women reported feelings of depression or other neurasthenic symptoms. In prospective studies where predrug assessments were established, only small degrees of change in behavioral or psychiatric symptoms have been noted 6 or more months after use of oral contraceptives was begun. Thus there is disagreement as to behavioral or mental effects of oral contraceptive drugs. The most commonly mentioned adverse effect is depression, especially among women with a predisposition toward, or previous history of, depressive illness or affective disorders.

No direct relationship has been established between use of oral contraceptives and increased behavioral or mental problems. Some women using an oral contraceptive report adverse mental or behavioral side effects, while others do not. These reactions appear to involve the woman's psychological state at the time she begins using the drug, her motivation to prevent conception, and expectations of the contraceptive, in addition to psychological history.

Expectations seem to be important. A high level of motivation to use a safe, secure method of contraception would seem to induce a woman to ignore suggestions of adverse reactions to oral contraceptives, and to ignore minor side effects and inconvenience. This motivation appears to derive from a desire for sexuality as well as a feeling of responsibility for contraception. Women lacking these motivations may attribute new or unusual feelings to the oral contraceptive, and may distort experienced side effects out of proportion.

Sexual effects—Although introduction of the pill was attended by warnings of increased promiscuity, moral decay, and reduction of sex drive, none of these conditions seems to have been brought about. Nearly all researchers report no change in sex drive or frequency of intercourse, nor have pre-existing sexual problems been reduced. The most often cited benefits are the spontaneity and satisfaction associated with the separation of the sexual and contraceptive acts.

Intrauterine Devices

Intrauterine devices have been used for over 2,000 years, but large-scale use did not occur until the inception of the Graffenberg ring in the 1930's. Construction of the intrauterine device (IUD) from inert plastics beginning in 1950 led to increasing popularity, and between 1960 and 1966 more than one million IUD's were being used by women in the U.S.

The IUD has become accepted as a method of long-term fertility control on a worldwide basis for several reasons: It has not been associated with pharmacological side effects, it is not an expensive permanent procedure, it separates coitus from contraception, and its effectiveness equals or surpasses that of methods such as the diaphragm, douches, condoms, etc. Still, the IUD is not universally acceptable. A number of physiological problems have been associated with these devices, and some women seem to be unable to tolerate their use over an extended period of time. Recently, there has been speculation regarding relationships between behavioral or psychiatric factors and physiological response, but no systematic research has been conducted. Nevertheless, patterns of use and response to the IUD which

are related to behavioral factors can be identified.

Motivating factors—The IUD has been thought of as having appeal to low socioeconomic-group women and those whose religious beliefs might preclude use of other methods.

In comparison to women selecting oral contraceptives, those choosing the IUD tend to be older, have had more children, and are less likely to be married. Studies classifying women using the IUD by socioeconomic status come to differing conclusions, depending primarily on whether data were gathered in a health department, hospital clinic, or planned parenthood center. In general, women of lower socioeconomic status favor the IUD and are more likely to continue to use it. However, no differences were noted in comparisons of specific attitudes toward the use of the IUD among women of high and low socioeconomic status. Differences were noted between women favoring or not favoring use of the IUD which were related to contraceptive background, sexual experience, and feelings about sexuality in general. Women favoring the IUD generally had experience with intravaginal contraceptive methods, were not bothered by the idea of masturbation or by the use of a tampon during menstruation, had positive feelings toward sexual intercourse, described their most recent sexual relationship in positive terms, and had experienced premarital intercourse. Women not favoring the IUD were likely to have opposite feelings and experiences.

Thus, socioeconomic status does not appear to influence women's attitudes toward the use of the IUD even though lower socioeconomic women are most likely to select it and to continue its use. The disproportionate extent of use of the IUD by lower socioeconomic-group women may be due in part to attitudes about sexuality, but the inexpense and convenience would seem to be important. Social, economic, demographic, attitudinal, and practical considerations affecting choice of the IUD would also seem to be important in a woman's response to this method of contraception and her willingness to continue its use.

Behavioral and psychiatric response—Rates of discontinuation of the IUD provide an index of acceptability and satisfaction. Rates of continuation of use vary, depending on the type of IUD and the design of the study. A report of continuation rates for the most widely used type of IUD was 78 percent after 12 months and 67 percent after 24 months. Pregnancy rates varied between 1.8 and 7.5 percent over a 12-month period, depending upon the type of device used. However, the device associated with the lowest pregnancy rate was also associated with the highest rate of expulsion and highest rate of removal for medical and personal reasons.

In a study of two groups of women, one using an oral contraceptive and one using an IUD, a number of women using the IUD had mild depressive reactions identical to those of women using oral contraceptives. In the background of these women there were no indications of tendencies to depression which might be reemerging under hormonal stimulation. This evidence was interpreted as an indication that these depressions have psychological roots and occur as a result of frustration over the interference of fertility.

Observations of 150 women, in whom an intrauterine coil had been placed, showed a relationship between psychological factors and acceptance or rejection of the IUD. Size of the

uterus and depth of the cavity were found to vary depending on the time in the menstrual cycle, position of the uterus, and degree of apprehension of the woman at the time this determination was made. Excessive or marked change in the size of the uterus or the cavity were noted almost twice as often in the woman who later expelled the coil or bled sufficiently to require removal. These findings were interpreted as an indication of emotional or neuromuscular factors in "acceptance" of the IUD. This interpretation was reinforced by the finding that 65 percent of those who expelled the device had in the past received, or were receiving, psychotherapy. Of those for whom the device was satisfactory only 5 percent had a similar history. Women for whom the IUD was most unsatisfactory were ambivalent toward pregnancy and childrearing, likely to be dismayed at the lack of control over the device, fearful of injury, and evidenced behavioral problems related to sexuality.

Sexual response—Observations have been made that women who tend to be sexually inhibited or to describe their sexual relationships in negative terms do not choose the IUD. Others have noted that women with emotional conflicts over pregnancy and childbearing or with problems related to sexuality do not find this method satisfactory. However, similar observations have been noted in conjunction with other contraceptive methods. In none of the literature was sexual or marital response explored in detail. There are allusions to dissatisfactions by husbands as well as wives, and other "personal" reasons possibly related to sexual response which seem worthy of investigation.

Fallopian Tube Ligation

Since sterilization by fallopian tube ligation was introduced in the U. S. in 1939, this procedure has become increasingly popular. By 1970, this number had increased by 161 percent.

Fallopian tube ligations have been regarded cautiously by physicians because of legal, moral, and religious questions. The operations are not sanctioned by certain religious groups, and only three States have legalized voluntary sterilization. In 27 States, tubal sterilization for therapeutic or eugenic reasons are legal. As a result of ambiguity as to the morality or legality of tubal sterilizations, most of these operations are performed only after a panel of physicians has ruled that an operation would be appropriate.

Motivating factors — Conditions under which tubal sterilization may be performed are so circumscribed that not every woman desiring it can obtain permission. Therefore, factors leading to a tubal ligation cannot be discussed as wholly "motivational." The typical fallopian tube ligation involves a woman over 30 years of age, with five or more living children, who is classed within the lower socioeconomic group in society.

In nearly all studies multiparity and/or socioeconomic circumstances are the most frequent indications or reasons for these operations. When multiparity alone is listed as the reason, the indication is 1 percent medical and 99 percent socioeconomic. This contention is supported by the majority of studies in the U. S. which show the most frequent indication for tubal sterilization is multiparity, and more than two-thirds of women obtaining these procedures are among the lower socioeconomic group.

No study analyzed the reasons for

which women elected a tubal sterilization. The composite of studies suggest women choosing these procedures have borne as many (or more) children as they had wanted, accepted responsibility for contraception, and from their personal circumstances viewed tubal sterilization as the safest and perhaps the most convenient method. Although contraceptive histories of these women are lacking, it seems tubal sterilization provides effectiveness they have not found in other methods of birth control. These operations (in the U.S.) are usually not permitted for women until they have had at least four children and have reached their 30th birthday. In the U.S. there is an average of more than five children per sterilized woman. In Switzerland, where age is not a consideration and tubal ligations are permitted for women who have three living children, the average number of children per sterilized woman is 3.6 percent.

The use of age and parity by physicians and hospitals as criteria results primarily from a lack of moral and legal clarity. It is assumed that use of these criteria helps to ensure satisfaction with the procedure performed. However, use of these criteria have had the effect of removing tubal sterilization as a method of birth control from a large proportion of the female population, and restricting its use primarily to the poor and multiparous. Furthermore, there is evidence that age and parity are not the most reliable factors in predicting satisfaction with operations to bring about the tubal sterilization.

Behavioral responses—Only one study mentioned an increase in psychiatric or behavioral problems among women postoperatively. This increase was slight, and not considered significant. Benefits were expressed in terms of a decrease in anxiety or nervousness, greater happiness or pleasure in interpersonal relationships, and in terms of a decrease in psychiatric symptoms or incidence of psychiatric illness.

Within the small proportion of women expressing dissatisfaction, a number of factors operate to effect these negative responses. Unstable marital relationships, previous history of psychiatric problems, affiliation with a religious body not condoning fecundity control, surgical complications or delay in recovery, and reversals in life circumstances have all been identified as adversely affecting women to some degree.

Although the age of the woman and the number of children she has borne are prime considerations in permitting tubal sterilizations, these factors do not emerge as reliable indicators of response of the operations. Women most satisfied had an average of three children, and those least satisfied had an average of six children. Only one study found evidence that women under age 30 are less likely to be satisfied with tubal sterilization than women over age 30. Results of other studies indicate age, by itself, is not a highly important factor in determining satisfaction. Authors of these studies caution against advocating tubal sterilization as a method of birth control among younger women because of its permanence and the possibility of future regret.

Although most tubal sterilizations are performed among women of low socioeconomic status, one study found that indigent women are less likely to respond favorably. It is possible that indigent women attach greater importance to their ability to procreate than do other women, but this had not been substantiated.

While a large majority of women respond favorably to tubal sterilization, some women experience adverse effects. Satisfaction appears to be associated with stability of marital relationship, previous psychiatric history, religious affiliation, success of the operation, and changes in life circumstances after the operation. Traditional factors used in making decisions for permitting the operations—age, parity, socioeconomic status—are less closely associated with satisfaction than with the procedure.

Sexual effects—In each study reviewed, small portions of study groups were found to have a less favorable marital or sexual adjustment. In no studies were reduction in frequency of intercourse, frequency of orgasm, enjoyment of sex, or compatibility with marital partner associated with tubal sterilization. Authors attribute these findings to greater relaxation about sexual relationships brought about by relief from anxiety about pregnancy and by separation of the contraceptive and coital acts. It appears adverse effects of tubal sterilization relating to sexuality are minimal. Positive sexual effects were noted in the majority of women. These positive effects were most often associated with a relief from anxiety about becoming pregnant and a greater spontaneity in sexual relationships resulting from the separation of coitus and contraception.

This review indicates the complexity and importance of behavioral factors in the choice, use, and continuation of noncoital methods of contraception. For each of the methods, convenience and effectiveness in limiting fertility and the ability to separate coitus and contraception are primary considerations in their selection. Yet, each of these methods is associated with adverse behavioral or psychiatric responses of varying degrees and over varying lengths of time. Although these responses can be attributed to physiological change in many instances, in others the responses appear to be more closely associated with the termination or limitation of the biological function of reproduction. Behavioral responses to these methods are many and varied, and seem to be related to previous social, cultural, or psychiatric history. Behavioral responses to these methods can be predicted on the basis of social and psychological factors with far greater reliability than reliance on legal or social sanctions or personal feelings of the physician.

Condensed with permission from *Social Science and Medicine*, 6(1):163–177, 1972.
Copyright 1972 by Pergamon Press Ltd.

Reprints of original article from Barry L. Borland, Ph.D., Department of Behavioral Science, The Milton S. Hershey Medical Center of The Pennsylvania State University, Hershey, Pa. 17033.

Prenatal Stress Feminizes and Demasculinizes the Behavior of Males

Ingeborg L. Ward

Sexual differentiation in male rats stressed during critical prenatal and postnatal development stages appears to take place in the presence of large amounts of the weak adrenal androgen, androstenedione, rather than under the primary influence of testosterone. The resulting behavioral potentials would be expected to resemble those obtained by other experimental manipulations which decrease functional testosterone titers. Male behavior should be reduced and female behavior enhanced.

In a study designed to test these proposals, 14 time-mated rats were stressed daily during three 45-minute sessions during days 14 to 21 of gestation by being restrained in 7-by-3 inch tubes across which 200 foot-candles of light were directed. This treatment produced piloerection and substantial amounts of urination and defecation. Nine control mothers were housed in an adjacent vivarium and were not handled. Half of the prenatally stressed litters and four of the control litters were then given daily postnatal stress from days 1 to 10 of age; stress consisted of three 30-minute sessions during which each male pup of a given litter was placed in a separate compartment of a plastic ice cube tray mounted on a vibrating metal rack. At about 90 days of age, all males were given 30-minute weekly tests with estrous-lure females for spontaneous behavior. Each animal continued to be tested until he had either ejaculated or had failed to copulate for 6 weeks.

A marked reduction was obtained in the percentage of prenatally stressed animals capable of showing the ejaculatory response. The postnatally stressed group did not differ from the control group, nor did the combination of prenatal and postnatal stress enhance the effect above that produced by prenatal stress alone. The prenatally stressed groups simply did not attempt to copulate. Those animals initiating mating usually did so by the second or third test. Only one male in each group copulated without emitting an ejaculatory response. If the pattern appeared, it was normal. The mean number of copulatory responses emitted preceding the first ejaculation, the time from the first copulation to the ejaculatory response, and the duration of the postejaculatory interval were not significantly different among responding animals of the different groups.

The males were then castrated and, after a 10-day recovery period, given 5 weekly injections of 0.1 mg. of estradiol benzoate followed 42 hours later by 1 mg. of progesterone. Beginning on the second week, female receptivity tests were given before the progesterone injection and 2, 4, 6, and 8 hours after. The number of times each animal was mounted by a vigorous male during a 10-minute period and the number of lordotic responses were recorded. Behavior was rated on a 7-point qualitative scale used in this laboratory with 1 indicating minimal and 7 maximal receptivity. All groups were mounted about an equal number of times, but the two prenatally stressed groups averaged over 3 times as many lordotic responses as the control group. Postnatal stress had no

significant effect on this or any of the other measures of female behavior. The enhanced tendency of the prenatally stressed groups to show female behavior is also reflected in the larger mean percentage of tests on which at least two lordotic responses were emitted and by the superior quality measures. Postnatal stress combined with prenatal stress did not increase the effect above that induced by prenatal stress alone.

The data support the hypothesis that exposure of pregnant rats to environmental stressors modifies the normal process of sexual behavior differentiation in male fetuses by decreasing functional testosterone and elevating androstenedione levels during perinatal development. During stress conditions plasma testosterone emanating from the gonads decreases while adrenal androstenedione rises. The molecular structure of the two androgens being very similar, it is postulated that the two hormones compete for the same receptor sites. Since androstenedione is a less potent androgen than testosterone, the decreased male copulatory ability and increased lordotic potential seen in the prenatally stressed animals of this study would be expected. The relative difference in potency between testosterone and androstenedione has been repeatedly demonstrated.

It is postulated that sexual differentiation occurs under the influence of a dual system. Normally, in males, gonadal steroids would assure the establishment of male copulatory potentials and suppress female lordotic behavior. However, under a variety of unfavorable environmental conditions which have in common the ability to activate the adrenal cortical response to stressor, the normal amount and ratio of testicular to adrenal androgen is altered, and, along with it, the relative potency of androgenic stimuli under which the tissues mediating sexual behavior differentiate. The resulting alterations in sexual behavior provide the basis for an effective population control mechanism, since offspring so affected would not possess the behavioral repertoire necessary to contribute to population growth. Thus, the environment, by triggering or failing to trigger an adrenal stress response, may control the reproductive capacity of successive generations of differentiating fetuses and, thereby, population size.

Although sexual differentiation in the rat spans both the prenatal and postnatal periods of development, in this study, stress was effective only during prenatal differentiation. This is not surprising since newborn rats pass through a stress-nonresponsive period for the first 10 days after birth. However, while the newborn rat lacks the normal adrenal response to environmental stress, its adrenals show an increased sensitivity to adrenocorticotropin (ACTH). We are currently testing the possibility that by stressing the mother, enough ACTH or adrenal steroids can be transferred to the pup through the milk to influence the process of sexual differentiation which, in the rat, continues to about 10 days of age.

Condensed with permission from *Science*, 175(4017):82–84, 1972. Copyright 1972 by the American Association for the Advancement of Science.

Reprints of original article from Ingeborg L. Ward, Ph.D., Department of Psychology, Villanova University, Villanova, Pa. 19085.

Effect of Brain Stimulation in Positive and Negative Reinforcing Regions in the Rat on Content of Catecholamines in Hypothalamus and Brain

M. E. Olds and A. Yuwiler

A number of studies have examined the general relationship between emotional behavior and brain monoamine levels. However, few have localized the neural regions involved in regulating the emotional behavior under examination and assessed concomitant local monoamine changes. Direct stimulation of the hypothalamus can elicit a variety of emotional responses depending upon electrode placement and stimulus parameters. Thus, stimulation can elicit fear, flight, and rage, and also, in some specific placements, stimulation can be "rewarding" in that animals will work for such local brain stimulation just as they will work for food reward or other reinforcers. Further, the hypothalamus is rich in monoamines and it is at least conceivable that such monoamines may be involved in mediating the emotional states elicited by direct brain stimulation. The results obtained by other studies suggest a nonspecific relationship between brain catecholamines and brain-rewarded behavior: A decrease in brain norepinephrine correlated not only with rewarding brain stimulation, but also with emotionality produced by a variety of stressors as well.

In this study we have attempted to examine more closely the relationship between catecholamine levels, stress, and specific behaviors elicited by brain stimulation. Accordingly, we have compared changes in norepinephrine and dopamine levels in hypothalamus with those in the rest of the brain in animals with electrodes in brain areas eliciting "rewarding" behavior, those with electrodes in brain areas eliciting aversive behavior, and controls. Subjects in the brain-rewarded group were limited to those in which stimulation produced a positive brain reward with a minimal of overt behavior stress. Subjects in the aversive group had electrodes in the dorsal tegmentum, an area believed to be cholinergic rather than adrenergic. Animals were examined after self-stimulation, forced stimulation, and without prior electrical stimulation. Stress was evaluated by classical endocrinological criteria of adrenal activation as well as by activity of the corticoid-sensitive enzyme, hepatic tyrosine aminotransferase. In combinations, these conditions permitted some assessment of the relationship between stress, regional catecholamine changes, and some specific behaviors.

Surgery and Behavioral Procedures

Adult male albino rats were used throughout the experiment. They were housed in individual cages under constant illumination and food and water were available throughout training. All brains were assayed for biogenic amines with the exception of the brain from one animal in each experiment which was set aside to serve as a histological control.

With the exception of an unimplanted control group of animals, a set of bipolar stainless steel electrodes was implanted either in the hypothalamus or in the dorsal tegmentum of each rat. Functional validation of these sites was made several days after surgery by training the animals in an operant situation with brain stimulation as the reward. All animals

implanted with electrodes in the hypothalamus were given daily 2-hours training sessions in a Skinner chamber where the depression of a lever was the response required to produce brain reward. On the basis of the number of responses during 10 daily consecutive training sessions, the animals were classified either as self-stimulators or as nonself-stimulators. All animals with hypothalamic electrodes were given self-stimulation training daily until the test day.

All the animals implanted with electrodes in the dorsal midbrain tegmentum were trained to escape brain stimulation by depressing a lever. After 10 consecutive training sessions to escape brain stimulation, and on the basis of response scores during the last four training sessions, these animals were classified as escapers and nonescapers. The nonescapers were discarded.

The group of self-stimulators was further divided into several subgroups. One subgroup consisted of animals allowed to self-stimulate immediately prior to decapitation (group II). A second subgroup consisted of animals given forced stimulation during the period preceding decapitation (group III). A third subgroup did not receive any stimulation during the period preceding decapitation (group IV). A fourth subgroup consisted of animals categorized as nonself-stimulators (group V).

The animals with electrodes in the midbrain were grouped as escapers and nonescapers on the basis of initial training. The escapers were subdivided into two groups: one which would be allowed to escape from brain shock during the 20-minute period preceding decapitation (group VI), and one which would not receive stimulation during the period immediately preceding decapitation (group VII). Brain assays were thus carried out on animals in a total of seven treatment groups:

(1) A group of unimplanted animals habituated to the Skinner chamber and allowed to remain in individual test boxes for 20 minutes prior to decapitation. These animals constituted the control group (group I).

(2) A group (II) of animals with electrodes at rewarding sites as determined during training and allowed to self-stimulate for 20 minutes prior to decapitation.

(3) A group of self-stimulators receiving "free" brain reward for a period of 20 minutes prior to decapitation (forced self-stimulators) (IV).

(4) A group of self-stimulators *not* allowed to self-stimulate prior to decapitation (III).

(5) Animals with electrodes in the hpyothalamus but at nonrewarding sites (nonself-stimulators). These animals were not stimulated prior to decapitation (V).

(6) Animals with electrodes at aversive sites (escapers) given a 20-minute escape session prior to decapitation. (VI).

(7) Escapers *not* given an escape session prior to decapitation (VII).

Values for catecholamines obtained for the hypothalamus and "rest of the brain" exclusive of cerebellum and olfactory bulb, and values for adrenal weight, adrenal corticords, and liver tyrosine aminotransferase activity were statistically analyzed for group differences.

Specificity of Relationship

Only three conditions produced changes in the levels of brain catecholamines, only one of which involved brain stimulation. Two of the groups had electrodes in hypothalamus and the other had electrodes lodged in

midbrain tegmentum. When changes were produced, they were seen in both the hypothalamic region and the "remainder of the brain." Alterations in norepinephrine levels were paralleled by alterations in dopamine levels.

Because of the postulated relationship between brain catecholamine levels and stress, three stress indicators were examined in some of the groups. Adrenal weight was determined to evaluate chronic stress effects attendant upon the initial training and screening procedures. Adrenal corticoids were determined to evaluate the stress components of the test session immediately preceding decapitation. Finally, tyrosine aminotransferase activity was taken as some measure of the stressor components of the preceding sessions.

It appears that these treatments did not result in a continual stress as measured by increased adrenal weight. Electrical stimulation to hypothalamus or midbrain did act as an acute stressor as measured by adrenocortical concentration per adrenal. The elevations in tyrosine aminotransferase activity in all treatment groups suggest some stressful carryover from training session to training session, but neither handling nor placement in the test box alone elicited adrenal activation.

It was the purpose of this study to obtain more direct information on the specificity of the relationship between brain catecholamines and self-stimulation behavior. The results support the view that such a relationship may indeed exist but they also underscore the complexity of separating reinforcing variables from the many other functions which are interdigitated in this highly complex part of the diencephalon.

Thus, the results of these experiments confirm earlier reports of decreases in brain norepinephrine content during self-stimulation. However, they do not confirm reports of a similar decrease during escape (i.e., lever pressing to avoid tegmental stimulation). Active self-stimulators had lower hypothalamic and brain norepinephrine and lower brain dopamine levels than controls, whereas animals actively escaping were indistinguishable from controls on these parameters. The stress indices examined also show that self-stimulation behavior is accompanied by elevated adrenal corticoid levels and elevated activity of tyrosine aminotransferase. Self-stimulation thus appears to be "stressful" by the criteria of adrenal activation. The same appears to be true for midbrain escape behavior as evidenced by adrenal corticoid content. Thus, it appears that a decrease in brain norepinephrine *concentrations* is not an invariant concomitant of stress as measured by adrenal activation.

Although both a decrease in norepinephrine concentration and adrenocortical activation were observed in self-stimulating animals, the degree of association between these phenomena is unclear. Thus, the decrease in norepinephrine could be attributed to the self-stimulation behavior or to stress, or to a combination of the two. Further, most stimulation points in the hypothalamus elicit both approach and avoidance behavior, and no attempt was made in the experiment to select self-stimulators showing only approach behavior. Consequently, it is conceivable that adrenal activation is a concomitant of inadvertent stimulation of escape components, while the norepinephrine changes result from activation of noradrenergic neurons participating in self-stimulation behavior.

The hpyothalamic reward system is rich in noradrenergic fibers, while the midbrain aversive system appears to

be relatively poor in such fibers. The differences in norepinephrine concentrations elicited by self-stimulation and escape could be attributed to possible differences in the transmitter systems involved in eliciting these two behaviors. However, this study measured only the concentration of catecholamines. Conceivably, then, the differences observed could reflect not the transmitter system involved, but rather the demands on that system. Further, it is conceivable that massive norepinephrine release during initial escape training resulted in increased synthesis of tyrosine hydroxylase, the rate-limiting enzyme in norepinephrine biosynthesis. Increases in adrenal and midbrain tyrosine hydroxylase activity in responses to chronic stressors have been demonstrated and analogous increases might have accompanied the training procedures employed here. Such an increase in enzyme activity might have been sufficient to compensate for norepinephrine loss during aversive stimulation and thereby permit maintenance of normal norepinephrine levels. The average number of reinforcing shocks was nearly 10 times as great as the average number of aversive shocks and, again, norepinephrine synthesis even if accelerated may still have been insufficient to keep pace with the demand. Against the possibility of compensatory increases in norepinephrine synthesis is the fact that brain norepinephrine levels were slightly lowered in unstimulated escapers. Such a lowering would not be expected if enzymic activity were elevated sufficiently to maintain normal levels in the face of aversive stimulation.

Finally, the decrease in brain norepinephrine during self-stimulation appeared related to elicitation of self-stimulatory behavior and not to stimulation of the hypothalamus alone. Thus, animals given forced hypothalamic stimulation did not respond with a decrease in brain norepinephrine. This difference is unexplained, but may be due to differences in the rate of brain stimulation. Self-stimulators receiving forced stimulation (group IV) were given one shock per second, whereas self-stimulators (group II) self-administered shocks at twice that rate. It is also conceivable that the catecholamine changes reflect activation of neural systems involved in the behavioral components of self-stimulation behavior and these systems might not be activated under conditions of forced stimulation.

These data underscore the multitude of factors determining brain levels of catecholamines and point to the complex relation between emotionality, the hypothalamus, and the catcholamines. Further work is needed to resolve the technical problem of disassociating the hypothalamic reward system from the host of other hypothalamic functions and to evaluate the relationship between self-stimulatory behavior and catecholamine metabolism.

Condensed with permission from *Brain Research*, 36(2):385–398, 1972. Copyright 1972 by the Elsevier Publishing Company.

Reprints of original article from M. E. Olds., Ph.D., Division of Biology, California Institute of Technology, Pasadena, Calif. 91109.

The Utilization of Research

Asher Soloff

It is often assumed that completion of a research project or demonstration will lead to its application. To believe so is naive. Spreading the word requires effort, getting it to all who can make use of it demands more effort, and, even if the efforts are carried out with sophistication, usage is not guaranteed. Getting more research utilized is a complex process that requires understanding beyond the know-how required for successful dissemination of knowledge.

The problems of getting research disseminated and utilized are receiving major attention. The U.S. Social and Rehabilitation Service (SRS) has established a Research Utilization Branch, and other Federal agencies, such as the National Institute of Mental Health, have set up utilization activities. We at Chicago Jewish Vocational Service (JVS) have set up, under SRS auspices, a Research Utilization Laboratory.

Objectives and Procedures

The Research Utilization Laboratory was set up to test techniques of packaging research results in ways that would suit the needs of practitioners. We assumed that the reasons given for problems in dissemination—e.g., reports being difficult to read, resistance to change, lack of familiarity between researchers and practitioners—were only part of the story. If agency staffs were to make use of research, the results would have to be "engineered" or adapted to their settings, to resonate with what has been called the culture of institutions, each agency's set of relationships and interactions, and the ideas, feelings, and myths that grow up around these patterns. Our major objectives are to select research appropriate to the needs of rehabilitation workshops, design packages for introducing the results of the studies, test the introduction in a small number of agencies, and disseminate the results of intensive efforts so that they would be utilized. Equally important is the aim to improve the atmosphere for using research in midwestern U.S., the region in which our Laboratory is functioning.

We first surveyed all rehabilitation workshops in a six-State region, asking what were the problem areas with which they would like help. We pinpointed eight areas where it would be feasible to conduct searches for relevant and helpful research. Each study started with a proposal describing research appropriate to a problem area, presented in a package intended to enhance its attraction and its usability.

After a period of learning we diversified our attack. We moved from describing the research in each problem area to organizing our presentations so that different kinds of research appeared in different kinds of packages. In our first major study, which dealt with techniques for evaluating the work potential of clients in workshops, we made use of predictive research and packaged it in a training program for improved observation. Areas of behavior that had been demonstrated to be critical for successful employment in industry for persons who receive training in rehabilitation settings were described in a manual for floor supervisors that also explained how the information could be used. The package simul-

taneously utilized the research on important client behavior and provided a format for using that knowledge to improve observation and evaluation of clients at work.

In our second study, we selected programs for improving job placement of handicapped clients and relations between workshops and employers. Those studies are being replicated by three agencies. Divergencies from the original studies are occurring, but replication is the basic procedure. This procedure comes closest to the classic image of innovation and the utilization of technology.

In our third study, we are building on basic research dealing with principles of behavior change to develop a procedure that supplements the workshop itself in helping clients to abandon inappropriate work behaviors and build new ones. The technique—structured role-playing of situations in which problems of interaction at work may occur—is not new. Our task will be to show workshops how to structure useful role-playing situations and make use of behavior change principles.

Problems in Research Utilization

But packaging is only a beginning. Acceptance and appropriate usage of research-based innovations require the presentation of ideas, materials, and techniques in a manner that minimizes interference with the interaction patterns or sets of relationships in an organization. It involves recognition of language barriers and the effects of frames of reference on understanding what is presented. It involves recognition of the sense of priority that exists in any organization, a sense that is responsive to demands from sources inside and outside the organization.

By interaction patterns I refer to the concrete sets of relationships within which the members of an organization carry on their work. The degree of decisionmaking authority the director of an agency retains for himself influences the way in which members of an organization respond to innovations. Without a director's support, the chances of bringing about change are limited. In an agency in which the director retains tight control over decisions, staff are not likely to be innovative or to accept new ideas. In an agency in which the director refuses to retain control, staff members are not likely to cooperate with one another in implementing any idea that is innovative.

We have been lucky in having the commitment of agency directors for the projects we have been testing. Luck, though, has been only a part of it, for we have followed procedures that would maximize the chance to find agencies with innovative and interested directors.

Working with responsive directors has been good, not just because it gives us entrée into organizations. It provides us with a guide to the general patterns of interaction in an organization, a guide who can help us to see where the pitfalls may be in getting material utilized and to deal with the resistances that inevitably occur.

There is danger in feeling satisfied with the success we had testing studies in agencies with innovative directors. It provides us with no data on procedures for introducing innovations in agencies where the interaction patterns are different and the director's influence less easily defined. In order to get some data, we have taken a first step in disseminating the results of our first study. We called together a group of persons representing 16 workshops in addition to the two work-

shops where the original evaluation package was tested. The study was discussed, and they were asked to return to their agencies with the materials and attempt to implement the procedure. They were offered consultation by phone and our project coordinator visited each State to conduct one training session. State vocational rehabilitation personnel provided advice and moral support to the agencies that were cooperating.

Thus we have a procedure in which agencies attempt to utilize packaged research products with less help than the original two agencies. Data will be available from these agencies to provide ideas on the impact of organizational interaction variables on the degree and effectiveness of innovation or research utilization efforts.

Most people who think about utilization are aware of the influence of these variables on the degree and effectiveness of research utilization efforts, but they are not so aware of the impact of language barriers and frames of reference. We tend to forget about subtle differences in word definition and the effects of frames of reference and organizational context on the salience and the meaning of words. How often have we all been frustrated in trying to convey something to people who then ask questions about some of the apparently simplest matters we have just finished describing?

It would be foolish to assume that the reason for difficulties in communication lies only in the stupidity of the audience or the incompetence of the speakers. Rather, associations and experience with words differ. Contexts in which words get their specific meanings for each of us differ. Frames of reference or points of view, in which words take on meaning, differ.

Some examples from our experiences may make what I am saying clearer. Within the field of vocational rehabilitatoin, the terms *evaluation* and *work adjustment* are technically differentiated. For those of us who were involved in the field before it grew to its present size and evolved its present structure, the distinction was relative. All clients were seen as being subjected to both processes simultaneously and throughout their rehabilitation programs. For more recent graduates of training programs in rehabilitation, the distinction between *evaluation* and *work adjustment* is more absolute. Each word denotes a self-contained variety of activities with different objectives. The first Laboratory Study dealt with *evaluation* as a topic separate from *work adjustment* although it was written and presented by people to whom evaluation and work adjustment are seen as simultaneous processes. In subsequent discussions concerning the plan of the study, confusion as to what was being asked of floor supervisors became evident. Some people assumed that the underlying "characteristics" of a client were being assessed prior to any consideration of adjustment, and mention of the relationship of the two processes in conjunction with one another created a block to further communication.

Definition of the phrase *research utilization* itself has led to misunderstanding, communication blocks, and barriers to the introduction of projects. People have come to associate specific behaviors and expectations with the word *research*. Many practitioners feel that demands will be made on their time and energy that will provide information to others but nothing of value to themselves, that data-gathering will interfere with the requirements of good rehabilitation

practice, or that the findings of social research are always subject to reversal and not to be trusted. They look for evidence of these expectations when relating to our coordinator, or to other researchers, and find it difficult to see what is being presented in the same framework as the presentor's.

The consequence of any problems interfering with the implementation of a procedure or an idea may be its rejection. But the result may not be that simple. Differences in degrees and forms of acceptance are possible, particularly when one is dealing with ideas or complicated procedures. Compromises are arranged, often not intentionally, so that the innovation is partially utilized, or utilized differently than intended, or becomes something else from what its originators or its disseminators planned.

These differences in degrees and forms of utilization pose the greatest danger in the dissemination-utilization process, for it is the possibility of unnoticed distortion that leads us to fool ourselves. We may see utilization where it has not really taken place, mistake appearance for reality, and congratulate ourselves for accomplishments we have not actually made.

Genuine and permanent change in organizations is difficult. People tend to forget that anything that interferes with the typical patterns of activity and relationships in an organization gets swallowed up, that there are natural efforts to incorporate it into the ongoing pattern rather than change the pattern.

Use of research on the attitudes and behavior of those whom we call the disadvantaged, particularly disadvantaged youth, is another example of the swallowing-up process. Data suggest that, while the aspirations of many disadvantaged clients for success at work are similar to other people's, they often place greater emphasis than do the disabled on having a say over how they are going to be helped. Many prefer not to be associated with the disabled but to be seen as persons with work problems. Many rehabilitators and agencies have redefined these findings to categorize clients into those who are "genuinely" motivated for work and those who are not, those who have "real" problems and those who are incapable of accepting help, those with high self-esteem and those with low self-esteem, and other categories. Even agencies that have served large numbers of disadvantaged clients tend to treat them the same way they treat the disabled. Awareness of their different perspectives has been admitted, but this knowledge has been redefined so as not to disturb the ways we integrate our efforts with those of clients. If we are unable to swallow up an innovation so it is no longer really there, we may simply let it fade away when rewards for effort have disappeared, returning to old habits.

Suggestions for Research Utilization

I have perhaps placed too much emphasis on the problems in research utilization and given the impression that it is almost impossible to get research utilized, or properly utilized. However, we know that research products and other innovations are being utilized all the time. People do seek ways to meet problems and they do try our materials, ideas, and techniques they find available. From the point of view of researchers, research utilization personnel, and government administrators, this interest is important, for it serves as the base on which planned research utilization can be built.

Research utilizers need skills and

techniques based on theory as much as other professional practitioners do. Let me offer some of the approaches we at the Research Utilization Laboratory would suggest. The suggestions focus on utilization and ignore the problems of planned dissemination.

First, it is important that the personnel of agencies adopting or testing innovations be involved in the process of planning implementation. By involvement I mean more than being informed or lectured at. Learning something new requires active examination of it. Accepting something new requires knowledge of how it will affect you and some feeling of control over the process. Without this involvement, innovations are in danger of being distorted or having their impact minimized.

Second, training programs should pay attention to constructs and ideas. Chances of misunderstanding are increased when techniques or actions are taught for their own sakes or isolated from their knowledge bases or their apparent areas of applicability. Let me add that it is not necessary to have college training to grasp ideas.

Third, pay special attention to the clarity of communication with which a research product or innovation is introduced. Not only is careful and simple writing or speech-making important, but the presentations are for audiences that are bound to be heterogeneous in the definitions of words and in the frames of reference that produce connotations.

Fourth, evaluate, where you can, the actual degree of acceptance. Genuine evaluation is an art and there will be little opportunity for it compared to the amount of time needed to disseminate and to utilize. Yet, without, on occasion, assessing the actual effects of an innovation in contrast to what is expected of it, we are likely to be fooling ourselves.

Fifth, and most important, planned research utilization requires new social institutions to make it reach the level of success being sought for it. New institutions have been created through Federal intervention. These are the Research Utilization Specialist positions in several States and the Research Utilization Laboratories, of which ours was the first. I would suggest another institution. We have found that much of the enthusiasm around testing research products and planning to use them comes from seminars in which discussion of problem-related research, techniques for implementation, and techniques for interagency cooperation takes place. Regular research-related or innovation-related seminars may elevate the levels of interest and actual utilization. The planners of such seminars would need to prepare materials and plan sessions carefully but our experience suggests that such seminars are useful tools for getting utilization of research started.

Condensed with permission from *Rehabilitation Literature*, 33 (3):66–71, 1972.
Copyright 1972 by the National Easter Seal Society for Crippled Children and Adults.
Reprints of original article from Asher Soloff, M.A., Research Coordinator and Supervisor, Research Utilization Laboratory, Jewish Vocational Service, 1 S. Franklin Street, Chicago, Ill. 60606.

The Viet Nam Veteran: Psychosocial Casualties

Peter G. Bourne

Although there is no doubt that the rate of psychiatric attrition during the year spent in Viet Nam by U. S. servicemen is lower than in previous wars, it is becoming increasingly apparent that this represents only a part of the overall picture of the psychological effects of this war on the men who serve. The psychological and social problems of the Viet Nam veteran probably exceed those of any previous conflict; yet many of the factors which help to keep psychiatric casualties low in Viet Nam ironically serve to compound the readjustment difficulties of the veteran when he returns.

Factors Influencing Adaptation

The single most important factor influencing psychiatric attrition in Viet Nam is the 1-year tour. A man knows that if he merely can survive for 12 months he will be removed automatically from the combat environment. Although it acts as a strong prophylaxis against the stresses of combat, the 1-year tour has other effects; it breaks down the tradition of the small unit. The rotational system staggers the arrivals and departures so that the G.I. feels no continuity with those who precede and follow him; he even feels apart from those who are with him, by rotating on a different schedule. He also has no investment in the war and its outcome.

Many G.I.'s are discharged from the service immediately upon their return to this country; but they do not return as victorious units to the acclaim of their fellow citizens. They return as individuals grateful to have survived, but without recognition or social support. Most returning G.I.'s go through a period of reentry shock lasting weeks to months, during which they are out of touch and bewildered. They are physically back in the States but psychologically and emotionally still in Viet Nam. The 1-year rotation compounds the problem by denying the individual any kind of supportive social system in which to make his readjustment to the American environment. In World War II the civilian population was actively involved in the war effort, and the entire country was actively geared toward receiving and accommodating the returning veteran. The lack of this type of support today leaves the Viet Nam veteran with a sense of complete isolation.

Not only does today's veteran have no individual support but he is also the victim of a uniquely unpopular war. Besides failing to receive popular acclaim, he may feel even more that he has become some kind of a traitor to his own generation. The only place he can go to be treated as a hero is to veterans' and civic groups from another era, whose behavior frequently seems irrelevant to the mainstream of life in America today, and with whom the generation gap is almost insurmountable. The only nationwide veterans' organization where he can find support and sympathy from his contemporaries is a group known as Viet Nam Veterans Against The War. It is of particular interest that the camaraderie that holds this organization together is clearly the result of the shared experience of Viet Nam rather than the antiwar commitment of the group.

For the individual to adjust most

comfortably and easily, it is not so important that he be treated as a hero, but that some recognition be given to the experiences and suffering he has endured. Without question, the combat experiences of most young veterans are the most significant events in their lives, seared into their memories so that they are repeatedly and sometimes compulsively thought about and relived. By their very significance to the individual and their importance to his self concept they serve to make him feel set apart from those who have not had those experiences, and also from those who are disinterested or unable to comprehend what those experiences were like and how enormously significant those events are to the way he now perceives himself.

In the war zone there is often the feeling that all usual social moves have been suspended, and individuals feel free to engage in behavior, both in and out of combat, that they would find reprehensible in civilian life. Because of the mixed messages the G.I. receives about the conduct that is acceptable in combat, it is not surprising that atrocities have occurred with such frequency. However, removed from the permissive and condoning environment of combat, many veterans re-examine their acts with horror when judged by the standards of the civilian environment to which they have returned. Many feel consumed by guilt over their acts; memories can keep the individual in constant turmoil from which he finds little relief.

Some returning G.I.'s often have found their Viet Nam experiences so extreme or even exhilarating that they develop a sense of nihilism, with difficulty finding motivation for the mundane demands of civilian life. In Viet Nam every day was a struggle for survival, and facing and overcoming life-endangering situations was a regular event. Civilian life can never match the emotion of these experiences. Under these experiences, the difficulty of becoming remotivated for civilian jobs or being satisfied with routine employment is apparent.

Other problems face the G.I. when he returns to civilian life. Employment is especially hard to find for the poorly educated and those with limited motivation. Furthermore, some employers refuse them jobs solely for fear that they may be drug users. There has been some deliberate victimization and outright hostility toward Viet Nam veterans by antiwar groups or individuals; some veterans are often hesitant to mention their involvement in the war among groups of their peers for fear of evoking a hostile reaction.

The problems for veterans are probably greatest for returning black G.I.'s. The army has traditionally been the one accessible and socially acceptable route out of the ghetto. Now antiwar sentiment has made military service less attractive. In Viet Nam, black G.I.'s are more likely to be killed and more likely to be exposed to traumatic combat experiences than their white comrades. When they leave the service they tend to have fewer marketable skills, face a bleaker job market, and return to a less desirable residential environment. Many have feared and some have hoped that the black veterans would become the leaders and organizers of a black revolutionary movement in the ghettos of America. However, for many black veterans the pervading pessimism reinforced by society's lack of concern generates a sense of utter futility which makes a violent ghetto insurrection seem irrelevant to their own problems.

Drug Abuse

The problem of drug abuse is regarded as an area in which the Viet Nam veteran differs totally from those of other areas. Among some units in Viet Nam the use of drugs is almost universal, and in the last 2 years the use of heroin in particular has increased at a spectacular rate. All drugs are readily available and they are cheap. Drug use has become not only the norm, but the use of marihuana in fact may be thought to have redeeming features by the fighting man. The relaxing effects of marihuana are beyond dispute and it seems that in some respects it has taken the place of alcohol in previous wars.

Use of drugs in the combat zone has a particular appeal because the psychological anesthesia provides a ready antidote to the environmental stress. Also there is often a reactive flight into hedonism after times of stress when the G.I. frequently feels that no pleasure should be out of his reach. He knows not only how near he has come to dying in past encounters, but also the possibility of death in the future, and he therefore feels entitled to immerse himself in immediate self-gratification. The alienation and frustration experienced by the veteran on his return increase the attractiveness of drugs as an escape.

Problems of Treatment

That the incidence of emotional problems, even the level of hospitalization, is so high among today's veterans, makes depressingly hollow the claim that we have cut combat psychiatric attrition to a minimum. Merely to delay the time at which the peak incidence of psychiatric breakdown occurs is not a notable accomplishment. Today's veteran often finds that by the time he develops readjustment problems he is disowned by the military and has difficulty getting assistance from the Veterans Administration.

The only reasonable solution to this problem appears to be for the Veterans Administration to assume responsibility for all Viet Nam returnees, whether they meet the strict criteria of eligibility or not. Reorganization of the regulations affecting accessibility of services may well be essential if these men are to be helped. Many require only an outpatient setting where sympathetic counseling is available. In particular, group settings where the individual can work through his feelings with other veterans can prove an effective and relatively economic method of meeting the needs of many Viet Nam returnees.

Condensed with permission from *Psychiatry in Medicine*, 3(1):23–27, 1972. Copyright 1972 by Greenwood Press, Inc.

Reprints of original article from Peter G. Bourne, M.D., Director, Georgia Narcotics Treatment Program and Assistant Professor, Department of Psychiatry, Emory University Medical School, 1364 Clifton Road, N.E., Atlanta, Ga. 30322.

mental health and the law

The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law

Marc F. Abramson

On July 1, 1969, a new mental health act went into effect in California. The Community Mental Health Services Law consisted of a revision of the Short-Doyle Act of 1957 and a new law, the Lanterman-Petris-Short Act (LPS). The Short-Doyle Act of 1957 was a pioneering effort to stimulate mental health programs on the county level by reimbursing 50 percent of approved county mental health program costs. The revised Short-Doyle Act was intended to increase the community's role in providing mental health services by making community mental health centers mandatory in counties with a population of 100,000 or more, increasing the State reimbursement to 90 percent (it had been increased to 75 percent in 1968), and establishing the principal of a single coordinated system of care for the mentally ill by making the counties pay for inpatient treatment of county residents at State hospitals.

LPS was intended to increase the legal rights and reduce the legal disabilities of mentally ill persons involuntarily detained and treated in mental hospitals. The criteria for initial involuntary treatment were made more stringent, and a graded series of standards was established; it requires the demonstration of increasingly severe impairment or dangerousness from mental disorder or chronic alcoholism in order to justify longer periods of involuntary detention and treatment. In general, these longer periods of involuntary treatment follow mandatory judicial hearings. In contrast, the initial, shorter periods require a less formal mental health certification procedure, with formal judicial hearings only on request of the patient.

LPS permits initial involuntary detention and treatment for 72 hours if a person is dangerous to himself or others, or gravely disabled as a result of mental disorder or impairment of chronic alcoholism. In LPS, the need-for-hospitalization standard is omitted. Dangerousness to self or others is not further defined in LPS, but "gravely disabled" is defined as being "unable to provide for one's basic personal needs for food, clothing, or shelter." The same criteria permit an additional 14 days of involuntary treatment beyond the initial 72 hours, and a further 14-day extension is possible for suicidal persons.

Thus, after 17 days (72 hours plus 14 days), involuntary treatment is no longer possible for a patient merely "dangerous to others." However, there is available a judicial commitment for 90 days for an "imminently dangerous person" who presents "an imminent threat of substantial physical harm to others." At the end of 90 days of this postcertification involuntary treatment, such an "imminently dangerous person" must be released. Repeat 90-day commitments are possible if the patient is demonstrably assaultive during inpatient treatment.

Few patients receiving tranquilizing drugs meet that criterion.

Suicidal patients must be released upon demand after 31 days of involuntary treatment, unless a judicial opinion of "grave disability" is obtained. In that case, a conservator is appointed for the gravely disabled patient, who can then be involuntarily detained and treated indefinitely with periodic judicial review of continuing "grave disability."

On one level, the new law seems to be working. The inpatient population of State hospitals is down, and the community is apparently providing local care for the mentally ill. However, there may be a limit to society's tolerance of mentally disordered behavior.

If the entry of persons exhibiting mentally disordered behavior into the mental health system of social control is impeded, community pressure will force them into the criminal justice system of social control. If the mental health system is forced to release mentally disordered persons into the community prematurely, there will be an increase in pressure for use of the criminal justice system to reinstitutionalize them.

As a psychiatric consultant to a county jail system, county courts, and the adult division of a county probation department, I believe that mentally disordered persons are being increasingly subjected to arrest and criminal prosecution. They are often charged with crimes such as public drunkenness, disorderly behavior, malicious mischief, or possession of marihuana or of dangerous drugs. Mentally deranged youth come to police attention because of disorderly behavior, and are found to have marihuana in their possession. Illegal barbituates are sometimes found on a comatose or groggy person following a suicide attempt.

Mental health professionals in California have tended to use a rather narrow definition of the criteria "dangerous to self and others" and "gravely disabled." The removal of the need-for-hospitalization standard in LPS as a sufficient criteron for involuntary treatment was interpreted by many mental health professionals as a rebuke to their exercise of professional discretion. There seems to be a passive-aggressive strictness to the way they have interpreted these new criteria for involuntary detention and treatment.

However, even institutional psychiatrists apply the LPS criteria strictly. Habeas corpus appeal is possible at all stages of LPS procedures, and few institutional psychiatrists are eager to argue with attorneys in court about the applicability of the criteria to the patient who demands his release. Some public-defender agencies in California are conscientious in providing aggressive representation for any involuntary patient who "wants out."

Police are aware of the stringent criteria under which mental health professionals are accepting responsibility for involuntary detention and treatment, and regard arrest and booking as a more reliable way of securing involuntary detention of mentally disordered persons.

Once the criminal justice machinery is invoked, it is frequently hard to stop. There seems to be pressure to justify an arrest by carrying the process through to conviction and sentencing.

Long-term commitment to a mental hospital is possible for some mentally disordered persons who are not considered gravely disabled, provided

they have been arrested. California statutes permit long-term civil commitment for users of hard narcotics; this procedure is usually invoked only after criminal conviction, prior to sentencing. Abusers of habit-forming nonnarcotic drugs are not vulnerable since provision for civil commitment was repealed after LPS went into effect.

The only indeterminate commitments existing in California are those for mentally disordered sex offenders (applicable only after criminal conviction), and penal-code commitments that follow the adjudication of mental incompetency to stand trial or of being not guilty by reason of insanity.

If a mentally disordered person is arrested, penal-code commitments can be used to secure long-term hospitalization. Raising the question of mental incompetency to stand trial sometimes permits psychiatric examiners to reintroduce covertly the old need-for-hospitalization criterion to secure involuntary treatment of the mentally disordered person for an adequate length of time, beyond the LPS time limits. However, the duplicity of this stratagem has an antitherapeutic effect on the patient and introduces artificial and irrelevant criteria for release from the hospital. This undermining of the criteria for incompetency to stand trial by the reintroduction of the need-for-hospitalization standard is in contrast to efforts to make criteria for mental incompetency to stand trial more explicit and operational.

There is no way to know how many mentally disordered persons are being processed by the criminal justice system into jail and prison, persons who before LPS could have been detained and treated in mental hospitals. Those diverted to hospitals by being considered incompetent to stand trial may be a tiny fraction.

This criminalization of mentally disordered behavior is not without its positive aspects. It may create a pressure to upgrade the quality of mental health treatment in correctional programs. It may help some mentally disordered persons by encouraging them to feel responsible for their behavior, and making them aware of precisely what behavior society permits and what it proscribes. Some paranoid patients may do well on probation for the additional reason that they do not have to damage their self-esteem by admitting to mental illness.

Despite these occasionally useful consequences, I think the general impact of this criminalization of mentally disordered behavior has been negative. In California a great experiment in social policy is under way that deserves careful observation and research beyond the impressions in this brief article. It would be ironic if the Magna Carta of the mentally ill in California led to their criminal stigmatization and incarceration in jails and prisons, where little or no mental health treatment is provided.

Condensed with permission from *Hospital and Community Psychiatry*, 23(4):101–105, 1972. Copyright 1972 by the American Psychiatric Association.

Reprints of original article from Marc F. Abramson, M.D., Psychiatrist, Courts and Corrections Unit, San Mateo County Department of Public Health and Welfare, Redwood City, Calif. 94063.

mental health news digests

National Academy of Sciences Studies Investment of Federal Funds in Drug Abuse Prevention

Over the past 3 years the Federal Government has invested large amounts of money in information and education programs pertaining to drug abuse. Implicit in the development of the programs was the assumption that education of the public and training of its caregivers would help to prevent the spread of drug abuse and would develop leaders capable of dealing more effectively with problems that lead to and arise from misuse of drugs. Yet the urgent pressures for action led to rapid implementation of the information and training efforts with minimal attention paid to operational guidelines, requirements for accountability, or criteria for evaluation. Consequently, at the present time Federal efforts in drug abuse information and education cannot be evaluated precisely; indeed the proliferation of funding mechanisms and programs makes it almost impossible even to measure the level of effort as it is represented in dollar amounts.

Through the Special Action Office for Drug Abuse Prevention and Treatment, the Government now has set up several mechanisms for evaluating educational materials as well as evaluating the impact of education programs themselves. In these efforts, one of the most difficult areas of study has been the impact of the mass media in drug abuse education. The National Academy of Sciences, on a contract from the National Institute of Mental Health, has undertaken the task of judging whether it is even feasible to evaluate the full impact of the mass media campaign on drug abuse. The Academy has established a Panel on the Impact of Information on Drug Use and Misuse whose members will conduct the feasibility study. If evaluation is deemed feasible, they will recommend to the Government strategies for ascertaining how mass media drug abuse information efforts affect the phenomenon of drug misuse and what impact they have on our society in general.

In order to determine the impact potential of the mass media effort against the background of other Federal drug abuse education efforts, the Academy Panel gathered information about the total Federal monies spent on drug abuse prevention and education. Their findings reveal that, for Fiscal Year 1972, drug abuse prevention funds were channeled through eight Federal departments: Department of Health, Education, and Welfare; Department of Justice; Department of the Treasury; Department of Defense; Office of Economic Opportunity; Department of Housing and Urban Development; Department of Agriculture; and Department of Labor.

The committed funds that could be traced totaled $38,000,000. It is known, however, that the total expenditure was larger than that, but some funding mechanisms are structured so that an exact accounting of monies allocated for specific programs is impossible without a survey through the State or local level.

The Department of Health, Education, and Welfare administered the largest proportion of known funds for prevention, with $11,800,000 channeled

through the U. S. Office of Education and $18,600,000 through the National Institute of Mental Health. Of the monies spent through NIMH, $11,100,000 were committed to public education and information programs. The Department of Justice administered $4,500,000 through its Bureau of Narcotics and Dangerous Drugs and $2,600,000 through the Law Enforcement Assistance Administration; together BNDD and LEAA allocated $3,050,000 to public education and information efforts.

The level of effort for public education on drug abuse cannot be measured reliably, however, by the $14,150,000 of committed funds. The Federally funded educational efforts were greatly amplified by the donation of free public service time through all mass communications media, and the Advertising Council estimates the value of the donated time to be at least $17,000,000. In short, Fiscal Year 1972 saw a minimum total investment of $31,150,000 generated by the Federal Government for public education efforts aimed at drug abuse prevention. (Adapted from a paper read by Dr. Joan Dunne Rittenhouse at the meeting of the Panel on the Impact of Information on Drug Use and Misuse, National Academy of Sciences, January 7, 1972.)

Drug Abuse Prevention Projects

The National Institute of Mental Health has recently awarded six grants for projects on drug abuse prevention.

Two awards are for large community-based drug prevention programs. The New York Medical College Division of Community Mental Health will educate the East Harlem community about drugs and attempt to provide social alternatives to drugs and care for those with drug-related problems. A team will disseminate information about drugs, using a face-to-face confrontation approach at schools, housing units, and public and private agencies. Two citizen-action organizations are cosponsoring the project—the Upper Park Avneue Community Association and The Massive Economic Neighborhood Development.

The Protestant Community Services of Los Angeles is providing adult drug education programs for church groups in 10 communities. Teams of educators from the Caucus on Dangerous Drugs, made up of agencies in programs of drug prevention, will work with church representatives to design and implement the drug education programs.

Two awards emphasize training for people who have to deal with drug abuse problems. The Spokane Drug Coordinating Council will establish a drug abuse training center that will use community resources and facilities to train teachers, counselors, nurses, police officers, ambulance drivers, and other personnel. The Spokane Community Mental Health Center, Eastern Washington State College, Deaconess Hospital, and The Leadership Institute will offer courses on counseling, crisis intervention, pharmacology, psychology, legal aspects of drug abuse, emergency treatment, and group techniques.

The Washington Center for Addictions in Boston is establishing an interdisciplinary consultation team as part of a project to develop and maintain an interagency training program. The project will develop training programs for some 50-100 agencies through the use of workshops and conferences pro-

viding information on research, treatment, legal changes, and government policies and programs.

The last two awards are exploring innovative approaches to the learning processes in an attempt to bring about attitudinal and behavioral change. The Port Washington (N. Y.) Public Schools will develop a curriculum in drug abuse education using television programs produced by the students. Paraprofessionals, teachers, and administrators will give technical assistance. Evaluation will be carried out with informational and attitudinal measures in pre- and posttesting.

Medgar Evers College (Brooklyn) is developing an antidrug culture on its campus. The "Brotherhood Against Death"—a new student organization with a voice in the college's policymaking structure—will work to encourage a strongly motivated counterculture with ways for controlling sale of drugs on campus. The faculty and community representatives will join with students to plan cultural, athletic, and educational activities.

AMA Statement of Medical School Education on Abuse of Alcohol and Other Psychoactive Drugs

The AMA's statement is directed toward the question of drug use and abuse, and includes principles pertaining to the problems of alcohol use and alcoholism, problems associated with dangerous and illicit drugs, and the abuses of drugs thought to be harmless. After reviewing the need and the complex nature of drug problems, it reviews the current status of medical education in the U.S. Pointing out that most medical schools are revising their curricula, the statement does not attempt to offer a specific plan or program in the traditional medical education format. Rather it emphasized a conceptual approach and delineates key concepts, assuming that each school will find the best way to implement the plan in its particular setting. It also stresses that medical students today are concerned about problems of drug abuse over and above their education needs; many of them have experimented with drugs, and some will still be using drugs.

The statement urges that the problems be studied in the context of a unifying concept of behavior which stresses the relationships and interaction among such factors as the structure, function, chemistry, and genetics of the human organism; pharmacological properties of drugs and action at various doses under various conditions; personality factors, motivations behind drug abuse; social group membership and the place of the individual in society; physical environment, historical traditions and other dimensions of time.

Because much of the scientific literature on drug use and abuse is inconclusive and based on inadequate research, provision in the curriculum for systematic critical literature analysis is recommended. Similarly, because physicians must be aware of attitudes about drugs, analyses of mass media presentations and studies on attitudes and beliefs are considered important.

Other topics covered are demographic considerations, common routes to drug abuse, special exposure of physicians, legal considerations, multiple drug use, and communication skills of the physician. Toward the end of medical school the students should have an opportunity to integrate their knowledge, with one part of this process involving responsibility for education

about alcoholism and drug abuse and taking part in preventive programs.

A reprint of this Position Statement of the AMA Council on Mental Health and Committee on Alcoholism and Drug Dependence is available from the AMA Department of Mental Health, 535 Dearborn St., Chicago, Ill. 60610.

New System for Classifying and Diagnosing Mental Illness

A group of St. Louis psychiatrists will interview several hundred psychiatric outpatients and their close relatives to test and refine a new classification system for diagnosing mental illnesses. The first year of the proposed 4-year study will be supported by an NIMH grant. Dr. Robert A. Woodruff, Jr., associate professor of psychiatry at Washington University, is the principal investigator.

Using a special 30-page interview form, a team of psychiatric residents will interview patients diagnosed 5 years ago, and also a large sample of first-degree relatives. The interviewers will not know the patients' previous diagnosis.

To test the classification system, Dr. Woodruff will determine whether or not patients receiving identical diagnoses initially show differences 5 years later in their illnesses. He also plans to follow up on the records of patients who had different diagnoses initially, but whose condition proved similar 5 years later.

The purpose of the survey of relatives is to determine whether or not there are increased rates of prevalence of psychiatric disorder in patients' families. This will aid in the study of genetic and constitutional factors in mental illness.

New Institute of Psychiatry at Northwestern

A new Institute of Psychiatry is being established at Northwestern University as part of the School of Medicine. Located on the Chicago campus, the Institute will stress community-related programs in its research, teaching, and patient care. It will give medical students practical experience in a wide variety of settings throughout the city. Continuing education for those working in mental health activities in the community also will be provided; supervisory personnel from agencies in the network of services will be able to take courses in management and administration, and training of various kinds will be available to staff personnel. Dr. Harold M. Visotsky, chairman of the department of psychiatry at the University, developed the program in cooperation with the Northwestern University—McCaw Medical Center and the Citizens Health Organization, which is made up of representatives of 35 community agencies and providers of health services.

Partial Care Service at a Mental Health Center

A partial care program has been in operation for over 2 years at the Community Institute for Human Resources, Boise, Idaho. It is designed as a preventive measure to keep people from going into or returning to mental hospitals. Persons are referred to the program by psychiatrists, physicians, and agencies in the surrounding area.

NIMH CLINIC LIBRARY

The total program is composed of five activity-oriented groups: modern dance, art, charm, recreation, and a humanities program. A director, an occupational therapist, and nine volunteers run the program which is designed to improve self-image, communication, and interaction with others. Motor activities are encouraged to allow release for anger, hostility, and frustration.

At present there are 69 patients participating in at least two groups with attendance of 4 to 8 months. Patients leave the group when their needs have been fulfilled or to enter jobs, vocational rehabilitation training, or college. Plans are being made to expand the program.

For information or slides write to Mrs. Jill Hoag, Director, Adjunctive Therapy, Community Institute for Human Resources, 1477 North Orchard, Boise, Idaho 83704.

New Research on Depression

Major new research into the psychobiology of the depressive illnesses has been launched by a team of investigators at the University of Pittsburgh and Columbia University. Supported by the National Institute of Mental Health, it is the first in a series of studies planned and developed by the NIMH Clinical Research Branch and the Ad Hoc Advisory Committee on Collaborative Studies of Depressive Disorders. Drs. Joe Mendels, Robert Spitzer, Eli Robins, and Jean Endicott are co-investigators in the initial project.

They will attempt to develop a descriptive base for future psychobiological studies of depression, involving a standard interview for data collection and scales for measuring patient behavior in the community and of environmental stress. They will establish information about diagnosis, psychopathological symptoms, antecedent historical events, and personal history of the patient population under study.

Pilot field studies will be made in Philadelphia, followed by a larger scale testing program in cooperating institutions outside Philadelphia, including the Carrier Clinic Foundation, the University of Iowa, Tucker Hospital, and The George Washington University.

The collaborative series of studies to follow will clarify classification of the illnesses, examine the role of genetic factors in the development of depression, and pursue a set of interrelated biological and psychobiological studies.

Recent Awards

Seymour S. Kety of Massachusetts General Hospital has received the Mental Health Association Research Achievement Award for outstanding research into the causes of mental illness. The award has a $10,000 grant and the McAlpin Medal in honor of the late William R. McAlpin, Jr., whose bequest made the award possible.

Paul D. MacLean, Chief of the Laboratory of Brain Evolution and Behavior at the National Institute of Mental Health, received the Karl Spencer Lashley Prize awarded by the American Philosophical Society.